

103
INLAND BARGE AND TUG INDUSTRY SAFETY

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Inland Barge and Tug Industry Safet...

SUBCOMMITTEE ON
COAST GUARD AND NAVIGATION
OF THE

COMMITTEE ON
MERCHANT MARINE AND FISHERIES
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

ON

**THE SAFETY OF THE INLAND TUG AND BARGE INDUS-
TRY AND INVESTIGATE THE CIRCUMSTANCES SUR-
ROUNDING TWO FATAL BRIDGE ACCIDENTS INVOLV-
ING THIS INDUSTRY**

OCTOBER 12, 1993

Serial No. 103-73

Printed for the use of the Committee on Merchant Marine and Fisheries



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INLAND TUG AND BARGE INDUSTRY SAFETY

TUESDAY, OCTOBER 12, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON COAST GUARD AND NAVIGATION,
COMMITTEE ON MERCHANT MARINE AND FISHERIES,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:05 a.m., in room 1334, Longworth House Office Building, Hon. W. J. (Billy) Tauzin (Chairman of the Subcommittee) presiding.

Present: Representatives Tauzin, Barlow, Stupak, Taylor, and Coble.

Staff Present: Elizabeth Megginson, Matt Szigety, Catherine Tucker, Bill Wright, Jim Adams, Douglas Cheramie, Sue Waldron, Lee Crockett, Joan Bondareff, Harry Burroughs, Cyndi Wilkinson, Ed Lee, and Margherita Woods.

STATEMENT OF HON. W. J. TAUZIN, A U.S. REPRESENTATIVE FROM LOUISIANA, AND CHAIRMAN, SUBCOMMITTEE ON COAST GUARD AND NAVIGATION

Mr. TAUZIN. The subcommittee will please come to order.

We will meet today to receive testimony on the circumstances surrounding two fatal bridge accidents involving towboats and barges and to discuss the safety of the inland tug and barge industry in general.

Amtrak's Sunset Limited derailed on September 22 while crossing the Big Bayou Canot Bridge north of Mobile, Alabama, killing 47 people. Earlier this year, on May 28, a woman was killed when her car plunged off the Judge Seeber Bridge in New Orleans. Both bridges were struck by barges.

Just yesterday, again another bridge was struck by a barge.

On September 30, Secretary Federico Pena directed the Commandant of the Coast Guard to review the adequacy of towboat manning requirements, the adequacy of marine casualty reporting requirements, and the history of incidents involving operators of the uninspected towing vessels. I commend the Secretary and the Commandant for this effort, and I look forward to receiving the results.

The Secretary called us a minute ago to wish us well on the hearings and to assure us of his untiring efforts to find solutions to the tragic accidents.

While we wait for the Coast Guard's industry review, I am going to initiate the process toward improving the safety of our inland waterways. This afternoon I will introduce The Towing Vessel Navigational Safety Act of 1993. The bill was drafted to fill the

gaping hole that currently exists in the regulation of uninspected towing vessels.

I understand that when the Coast Guard boarded the towboat that struck the Big Bayou Canot Bridge, they found its wheelhouse lacked a nautical chart of the area that it was attempting to navigate. What is even more surprising is that the vessel was not required to carry a chart. Small wonder that the captain wandered off course. For that matter, the vessel was not required to carry a compass, radar, a fathometer, or any navigational equipment. The only equipment that was required in the wheelhouse was a radio. My bill will simply mandate that all towing vessels must carry basic navigational tools.

In addition, my bill will underscore the importance of The Towing Vessel Manning Report that has been initiated by the Coast Guard. Human error by licensed personnel caused both of the accidents that we will hear about today in all probability. It is time to review the Coast Guard's manning and training standards for uninspected towing vessels.

Finally, I want to recognize the valiant efforts of those Amtrak and Coast Guard personnel who courageously responded to the chaos that must have followed the Sunset Limited derailment. I look forward to hearing the views of our distinguished panel of witnesses, and I ask that each of you please summarize your testimony. Your written statements will be made a part of the hearing record as is our procedure.

Gentlemen and ladies, a single isolated barge bridge accident is one thing. When they come in a series and when they begin to produce the toll of injuries and deaths that we have seen in recent days, I believe it is incumbent upon all of us to find out why and to do expeditiously what can be done to assure that lives are not lost in the future in similar accidents.

We have already found some areas that immediately need improvement. It is our hope, in these hearings, that we can find remaining errors and we can begin to plug those holes and have a safer industry, both for the maritime industry and for rail and bridge traffic.

In that regard, we will be looking at the availability of new technology, including the new satellite positioning technology, to see whether or not, in fact, that technology can help us in this and similar incidents.

On November 12, we will be conducting a field hearing in Louisiana to look at the river situation. We are about to introduce a whole bunch of gambling vessels to the river scene already cluttered with barges and vessels carrying all sorts of dangerous cargoes.

The introduction of passenger vessels with many people revelling and gambling and having a good time on the Mississippi river is one that disturbs us as we begin to consider how safe our navigational systems are and how safe our river systems are.

Today is the beginning of that process. November 12 we will focus on the Mississippi River itself and on the area that has been identified by the Coast Guard as the greatest port need in America, the area from the mouth of the river to Baton Rouge where there is not even a single vessel traffic system installed. We are still

waiting for the appropriation and execution of funds to install such a system.

Ladies and gentlemen, thanks for coming today and for sharing your views with us. We will ask for your summaries in a second.

Let me recognize the Ranking Minority Member, Howard Coble, my dear friend for his opening statement.

STATEMENT OF HON. HOWARD COBLE, A U.S. REPRESENTATIVE FROM NORTH CAROLINA, AND RANKING MINORITY MEMBER, SUBCOMMITTEE ON COAST GUARD AND NAVIGATION

Mr. COBLE. Thank you, Mr. Chairman. I want to thank you for calling this very important hearing. And this, as you point out, Mr. Chairman, was, indeed, tragic the matter between the Amtrak Sunset Limited and the North Claiborne Bridge. And I think this strongly illustrates that our subcommittee should examine very closely and perhaps even consider amending—and perhaps your proposed bills will do this—the current manning and equipment requirements for inland towing vessels.

I will also be interested in hearing the Federal investigative agencies' and other witnesses' explanation of this of the inconsistencies that appear in the reports of the crew members of the *Mauvilla*.

I am particularly concerned about the 15-minute time period delay between the Sunset Limited's derailment and the report of this tragedy to the Coast Guard.

Thinking aloud now, Mr. Chairman, I realize it is easy for us to sit here and apply 20-20 hindsight; but I am thinking what could have been done had a timely report been made immediately? Perhaps the entire episode could have been avoided.

I recall the *Valdez* oil spill, one of the salient omissions that plagued everybody was the matter of delay, not timely responding. And I would hope that we would apply corrective measures to correct omissions of previous tragedies. They don't have to be identical. We don't have to wait to apply corrective measures to the next oil spill. We can apply them to results of tornadoes, hurricanes, and yes, even train wrecks.

And so I hope today, Mr. Chairman, this will be illustrative and revealing; and I expect it will be.

And, Mr. Chairman, I would like with your permission to enter into the record the statement of Congressman Fields, the Gentleman from Texas.

Mr. TAUZIN. Without objection.

[The statement of Mr. Fields follows:]

STATEMENT OF HON. JACK FIELDS, A U.S. REPRESENTATIVE FROM TEXAS, AND RANKING MINORITY MEMBER, COMMITTEE ON MERCHANT MARINE AND FISHERIES

I commend the Chairman of the Subcommittee for holding this hearing today, and hope that our witnesses will be able to shed some light on the causes of these tragic incidents. Later this year, the official investigations on these accidents will be complete, giving us additional information to consider.

As these accidents show, safety on the waterways is important to protect not only the lives of crew members who work on the water, but also the lives of individuals travelling on bridges and other areas around the water. We must increase safety standards to prevent fatal accidents of this type from occurring again, and I support early action to make these changes to the law.

Mr. TAUZIN. I want to commend the gentleman for highlighting that big concern. I hope we get some answers today on why there was such a long delay in reporting the Amtrak accident. We need to know what could have been done or what should have been done to expedite the reporting of the accident to the Coast Guard. Are we equipped to transmit emergency information to the Coast Guard and Amtrak to avoid similar accidents in the future? We will be exploring the answer to that question, we hope, in these hearings today.

I turn now to Mr. Stupak for an opening statement.

**STATEMENT OF HON. BART STUPAK, A U.S. REPRESENTATIVE
FROM MICHIGAN**

Mr. STUPAK. Thank you, Mr. Chairman. I will be very brief.

Having been a law enforcement officer for 13 years and having done a lot of accident investigations, I look forward to this testimony today. Like other Members of this group, I have plenty of questions, and I look forward to answers and look forward to working on this very important issue and look forward to your hearings in November and viewing the scene a little better.

Mr. TAUZIN. The gentleman from Mississippi, Mr. Taylor.

Mr. TAYLOR. I have no opening.

Mr. TAUZIN. The Chair is pleased to welcome our first panel of witnesses and to call your attention to the fact that the Washington Post yesterday contained a story entitled "The Recent Bridge Accident, A Scene Of The Wakeup Call On Safety." As you know, this has caught the Nation's attention. This tragic scene in Mobile is one that is still fresh in the Nation's mind, and we want to know why, what happened, and what we can do to avoid it.

We are pleased to welcome Mr. George Reagle, Director of the Office of Surface Transportation Safety National Transportation Safety Board; Rear Admiral James Card, Eighth District Commander, United States Coast Guard, accompanied by Mr. Grady Cothen, Assistant Administrator for Safety Federal Railroad Administration; and Mr. Dennis Sullivan, Executive Vice President and Chief Operating Officer of the National Railroad Passenger Corporation.

We will begin with you, Mr. Reagle.

STATEMENT OF GEORGE REAGLE, DIRECTOR, OFFICE OF SURFACE TRANSPORTATION SAFETY, NATIONAL TRANSPORTATION SAFETY BOARD

Mr. REAGLE. Thank you. Good morning, Mr. Chairman and members of the subcommittee.

Before I begin, I might mention in addition to the accident you mentioned on Lake Ponchartrain, I believe on Sunday, there was also an accident in Alabama involving a tow and a barge that hit a bridge on the Mobile River. So we have another additional accident.

Mr. TAUZIN. Mr. Reagle, also just for purposes of introducing this subject, this morning we all saw a news story that the very bridge in which this Amtrak accident occurred was struck in 1931, a similar accident.

Are you aware of that accident?

Mr. REAGLE. I am not certain of that.

Mr. TAUZIN. There was a story in New Orleans just this weekend on it. It seems to be a tragic reoccurrence of something that happened years ago.

Mr. REAGLE. As you mentioned, the Safety Board is currently investigating two accidents in which a bridge was struck by a marine vessel. The most recent accident occurred on September 22nd, 1993. The Amtrak Sunset Limited, derailed on a CSX Transportation, Incorporated, railroad bridge over the Big Bayou Canot near Mobile, Alabama. The entire train derailed, and one span and the timber trestle were destroyed. Forty-seven people were killed.

On the morning of September 22, 1993, the towboat Mauvilla proceeding up the Mobile River from Mobile, Alabama, to Birmingham, Alabama, pushing six barges, became lost due to dense fog. Prior to the derailment, the crew thought they had run aground; however, the preliminary information indicates that the tow may have struck the railroad bridge.

NTSB investigators are currently examining all aspects of the accident, including the track, the signal system, the condition of the bridge and the bridge permit and inspection records, vessel traffic in the bayou, aids to navigation, Coast Guard and company oversight of towboat operations and practices, the U.S. Corps of Engineers oversight of the waterway, towboat operating requirements and practices, towboat employee qualifications and training, the condition of the towboat Mauvilla and on-board equipment, and the towboat's maintenance records.

Another accident currently under investigation occurred May 28, 1993, in New Orleans, Louisiana, when the U.S. towboat Chris, pushing an empty hopper barge, hit the Judge Seeber Bridge. The impact resulted in the collapse of a bridge pier and 145 feet of the bridge's deck. The bridge deck fell onto the barge and into the New Orleans Inner Harbor Navigational Canal. Two automobiles containing three persons also fell killing one of the motorists and critically injuring two others.

As a result of this accident, the canal was closed to all navigation traffic for approximately 30 hours and the bridge was closed to highway traffic for two months. The damage to the bridge was approximately 1.5 million and to the barge 7,000. Towboat Chris was undamaged.

Federal bridge permitting procedures including pier protection were discussed in a recent Safety Board hearing by U.S. Coast Guard representatives, and testimony was also presented on railroad bridge pier protection practices over navigable waterways.

The Safety Board issued its first safety recommendation regarding the collapse of a bridge struck by a vessel following an accident that occurred on November 7, 1972, in Brunswick Georgia. Since that time, many safety recommendations have been issued to prevent collisions with bridges by marine vessels.

The recommendations have been related to the following issues: improved bridge protection devices, vehicle barriers and warning devices, bridge marking systems; improving the information available to towboat operators who are required to navigate under bridges; requiring that towboat operators be tested on their local

knowledge of waterway on which they navigate; and, finally, bridge vulnerability risk assessments.

The Safety Board believes that much positive work has been accomplished in these areas but, as evidenced by these two recent tragic accidents mentioned, more is needed.

Again, the Safety Board welcomes the opportunity to appear before you, Mr. Chairman. And I would be pleased to answer any questions you may have.

Mr. TAUZIN. Thank you very much.

The young lady that was killed in New Orleans at the Judge Seeber Bridge was also carrying a child, and, in fact, two lives were lost in that tragic accident.

[The statement of Mr. Reagle may be found at end of hearing.]

Mr. TAUZIN. We will now hear and welcome Rear Admiral James Card.

STATEMENT OF REAR ADMIRAL JAMES C. CARD, EIGHTH DISTRICT COMMANDER, UNITED STATES COAST GUARD; ACCOMPANIED BY: GRADY COTHEN, ASSISTANT ADMINISTRATOR FOR SAFETY, FEDERAL RAILROAD ADMINISTRATION

Admiral CARD. Thank you, Mr. Chairman.

I am Admiral Jim Card, and I am the Coast Guard Commander of the Eighth Coast Guard District, which is headquartered in New Orleans. Our district includes the areas where these accidents under investigation took place.

Coming before you to discuss these tragic events surrounding the Judge Seeber Bridge accident on the 28th of May and the Amtrak derailment on the 22nd of September is deeply disturbing to me, but accidents such as these demand that we review our oversight and regulatory policies concerning the Nation's inland marine transportation industry.

We in the Coast Guard have a paramount interest in the safety of the people who travel over the water as well as those on the water. All of us in the Coast Guard work hard to minimize the number and the magnitude of marine accidents through regulation and education. Yet, here I sit today to discuss the nature of and the facts surrounding two accidents where vessels engaged in marine commerce appear to have resulted in the premature deaths of many of our fellow citizens.

We in the Coast Guard are striving to do all that we can to make the waterways of this Nation safer. We will review our regulatory oversight policies, and we want to work with the Congress, and your subcommittee particularly, to prevent similar accidents in the future.

On the 27th of September, as a result of these accidents, the Commandant of the Coast Guard, as directed by the Secretary of Transportation, ordered a complete review of the Coast Guard regulation and oversight of inland marine transportation system. This review should be completed in December and will be available to you when it is.

The areas of review include: one, the adequacy and the effectiveness of the requirements for licensing of uninspected towing vessel operators; two, the history of incidents involving operators of unin-

spected towing vessels; three, the adequacy of the requirements for reporting marine accidents and hazardous conditions involving vessels and the adequacy of penalties for failure to report such accidents; and, four, the adequacy of the aids to navigation system for marking bridges and for marking the approaches to bridges over navigable waterways and the adequacy of navigation equipment requirements for uninspected vessels.

And although I cannot tell you today what the result of that is going to be, I can tell you some of the details surrounding the circumstances and what we are doing in the operational command about this.

You have heard a summary of both of the accidents. Let me indicate a few other things having to do with the Judge Seeber Bridge accident. The towing vessel Chris was pushed into the bank just above the bridge waiting to go through the industrial lock. That is not uncommon for that area.

According to our records, some 40,000 vessels transit through that lock every year. And also our records show there have been almost no accidents in this area before this time.

As they were waiting in that area, they had a problem with one of their engines and the captain of the vessel went down below to help with that. When he went down below, the towboat moved off the bank and slid down toward an unprotected part of the bridge; and you heard the results.

Following that accident, the towing vessel operator was charged with negligence. The hearing for negligence was held on the 3rd of September. The operator pleaded no contest, and the administrative law judge found that the charges were proved and the operator's license was suspended for four months followed by probation for 12 months, during which time the license could be suspended for six more months. The operator had been operating towing vessels 16 years and had no prior problems.

In response to that accident, the Coast Guard's response was immediate. It was right across from our Coast Guard base. The Coast Guard personnel from the cutters Pamlico, Wedge, and White Holly, who witnessed the collision and bridge failure, had boats on the scene in five minutes and a helicopter arrived within 25 minutes. We were able to do what we could in responding to that accident.

Our personnel immediately contacted the operations center at Group New Orleans and responded to the accident.

I know that today there will be a lot of questions having to do with what is going on in the Amtrak derailment investigation. The investigation is being headed by the National Transportation Safety Board and the Coast Guard is participating with the NTSB in that investigation.

We indicated that the Coast Guard's first notification that there was a problem came to us almost parallel in two ways. One was from a CSX railroad bridge operator to our Marine Safety Office indicating that there had been a passenger train derailment. That happened at 3:05 in the morning.

About the same time, the towboat Mauvilla indicated that they had a problem with their tow and that the barges had broken free.

The first report from the Mauvilla did not indicate that there were any other problems.

About three or four minutes later, the Mauvilla called back and indicated that there was a train derailment with fire and people in the water.

There have been many, many other accounts of the accident during that time. That is all under investigation. Gathering together all of those pieces is going to take some time. I don't have any more information personally on the sequence of events or the timing. I am sure that will come out in the investigation.

Let me say that once we were notified that there was a problem, we worked with all the other people in the area to respond the best that we could. We had a boat under way within 15 minutes and subsequently had almost 15 vessels, seven aircraft, which included six helicopters, responding to the scene.

The Coast Guard response, I think, was favorably influenced by work that was done in June of that year. The Chief Boatswain, Chief McClain who was the Officer in Charge of Station Mobile, felt that we ought to have a joint disaster drill with all the people in that area. They were looking more at an airplane accident as opposed to a train accident.

But in June of that year, Coast Guard Group Mobile, the Marine Safety Office, our Aviation Training Center (ATC), the Coast Guard Auxiliary, the Alabama Marine Police, the Mobile County Sheriff's Office, the Mobile County Sheriff's Civilian Flotilla Divers, the fire department and the police department all participated in the exercise. That exercise allowed them to look at the command and control and a lot of the other things that you would do in a tragedy of this sort.

Because of that, the response to this accident was enhanced and the Chief was on site as the on-scene coordinator, during most of this time.

We started our casualty investigation; and during our initial interviews with the Mauvilla's crew, they indicated there was no problem with the bridge.

Our investigator returned to the scene and started to find that there was some concrete on one of the barges and was working further with other agencies by looking at other aspects of this casualty.

As I said earlier in the testimony, the NTSB was directed to do the casualty investigation. In addition to the casualty investigation, there was also a criminal investigation done by the criminal task force in Mobile County and includes members of the Alabama Marine Police, the FBI, Mobile District Attorney, the police and the sheriff's department from the County of Mobile. The Coast Guard is going to wait for the results of that—both investigations—before we start any administrative or civil penalty procedures.

In addition to the review being conducted by the Commandant that I mentioned, we, who are in the operational command of the Eighth District, have looked at several aspects of the case to improve our operation. We had in place a protocol to notify bridge owners and bridge operators that there was an accident with their bridge, but we reinforced that throughout our District.

We developed a new protocol, since that time, where the bridge owner would be notified immediately of an accident with their bridge. And we are working together with them in sort of a test of that for the 24-hour emergency contact procedure.

Secondly, we are reviewing our aids to navigation in the Mobile River. The way that we do that, we have a waterways analysis and management system which looks at all the navigational aids in the area and takes information from the waterway users, as well as from other people and compiles it. We had completed that review in October of 1992, but because of this accident, we are doing that again.

Thirdly, we looked at the lighting on the bridge at the Big Bayou Canot. Since that is not a commercially used waterway, no lighting is required nor is a bridge permit required. And, according to our current procedures, if that bridge were built today, that would also be the case.

I realize that no amount of investigation or analysis can restore the lives lost in these tragedies. I believe that the Coast Guard is proceeding on many fronts to improve water safety.

We in the Eighth District are completing a review of all towing industry marine casualties including bridge collisions within our district's waters. In addition, each of our seven marine safety offices will be holding meetings with the towing companies within their area of responsibility to focus on local problems and communicate our concern for safety.

In addition, I will be holding a summit meeting later this month with the leaders of the towing industry and their industry association, the American Waterways Operators. These action are aimed at identifying problems and solutions that are in the purview of the district and heightening the safety consciousness of the towing industry. With our local action, plus the global work being done by the Commandant, we hope to improve the safety of our inland waterways.

Let me add, Mr. Chairman, that I do have some information about the incidents you talked about. On the Mobile River at about mile 14, which is the next railroad bridge up from the Big Bayou Canot railroad bridge, the towboat Elizabeth, a 130-foot twin screw towboat with 3,800 horsepower, was pushing eight barges. The bridge swung open; and as they were going through the bridge, they struck and bent a hydraulically controlled wedge which supports and aligns the swing bridge. When they bring it back, they have to have some mechanism for leveling the track and they hit that on the way through which caused that to be inoperative. And now the bridge has to be operated by hand when they bring it back and adjust the track.

I don't have any indication as to what happened or why that occurred, but it is under investigation right now.

There was also an accident yesterday involving the towboat Ruth, a 660-horsepower, 60-foot towboat pushing a 140 by 70 foot derrick barge; and it ran into a highway bridge just outside of New Orleans. I think the bridge is damaged to some degree, but it is open right now to navigation. And, they are looking to repair that. The preliminary information is that perhaps the towboat didn't

have enough horsepower to push that derrick barge through that section of the bridge.

So there were two accidents yesterday. I will provide some information on both of those accidents for the record.

Mr. TAUZIN. Thank you.

[The statement of Rear Admiral Card may be found at end of hearing.]

Mr. TAUZIN. And finally, Mr. Dennis Sullivan, Executive Vice President and Chief Operating Officer of the National Passenger Corporation, Amtrak.

STATEMENT OF DENNIS F. SULLIVAN, EXECUTIVE VICE PRESIDENT AND CHIEF OPERATING OFFICER, NATIONAL RAILROAD PASSENGER CORPORATION (AMTRAK)

Mr. SULLIVAN. Thank you, Mr. Chairman, Members of the committee.

I am Amtrak's Chief Operating Officer. And before I start, I would like to take a moment to say how deeply saddened I and all of us at Amtrak feel about the tragedy that happened on September 22, to Amtrak's Sunset Limited. I want to extend our heartfelt condolences to the family of all of those who didn't survive this accident, the 42 passengers, as well as Amtrak crew members Ronald Quaintance, John Wilson, Ernest Russ, Billy Ray Hall, and Michael Vinet. They will also be missed.

I am here today to briefly state the facts related to Amtrak's operation and answer any questions that I can for the committee. I want to emphasize that my testimony will be limited to what we think about Amtrak's operation.

At the time of the accident, the Sunset Limited, which was traveling from Los Angeles to Miami, had three locomotive units and eight cars and was carrying 192 passengers and 18 employees. The accident occurred while crossing the Big Bayou Canot bridge approximately 10 miles north of Mobile, Alabama. This section of railroad is level and tangent and has continuously welded rail on the track.

The train derailed because a section of the bridge had been struck by a tug and its barges had been knocked out of line about three and one half feet. This shift left a bridge girder fouling the track for our oncoming train. When Amtrak's locomotive struck this girder, the bridge collapsed and the Amtrak trains derailed and plunged into the water. All three locomotive units and four rail cars went off of the bridge. The lead locomotive was embedded in the mud of the east bank of the bayou and tragically one rail car, a coach, was entirely submerged in approximately 25 feet of water.

There is no evidence indicating any failure on the part of the Amtrak train crew or equipment or on the part of CSX's track signal system or bridge. In fact, if anything, our Superliner cars demonstrated some of the benefits of recent safety design improvements, particularly the superior braking that prevented four of the cars from tumbling into the water. Toxicological tests conducted by the National Transportation Safety Board on the crew members

who operated the train have found no evidence of drug or alcohol use.

Even though the bridge shifted three and a half feet, the signal system remained fully operational. Since the track and particularly the rails had not been broken, the circuit remained intact.

While we are not prepared to discuss the details of the investigation, Amtrak is convinced that the bridge shifted because it was struck by a commercial tug pushing six barges. The bridge is low, only 7 feet above the water, and is over a body of water which is not used for commercial river transportation or by vessels at night-time and is not a navigation channel. The railway bridge was designed to be a swing bridge; however, to the best of our knowledge, it has never been used as a swing bridge to allow water traffic to pass.

This railroad bridge has been at this location and in the same general configuration for over a century. It was bolted shut to fix it in place some 50 years ago. This bridge is inspected annually as all railroad bridges are and was last inspected by CSX Transportation on February the 10th of this year.

The track itself is inspected twice weekly and was last inspected on September the 19th, 1993. No problems were reported.

At about 2:01 a.m., about one hour before the Amtrak accident, a CSX freight train crossed the bridge traveling in the same direction. It crossed without incident. The CSX train had 74 cars and was approximately five times as long and weighed about eight times more than Amtrak's Sunset Limited.

CSX Transportation has estimated the time of the derailment to have been 2:53 a.m. The Sunset Limited passed the last controlled signal at 2:48:48 a.m. We understand that the train speed tapes are still undergoing calibration by the National Transportation Safety Board, but we believe that once all of the evidence is available, it will be determined that the bridge was struck and its girder span shifted between 2 and 3 a.m., the time between when the CSX train crossed safely and the Amtrak train derailed.

There appears to be little question that this accident was caused because a vessel or vessels struck the railway bridge with sufficient force to knock its girder span approximately three-and-a-half feet off center and that it happened after 2:01 a.m., when CSX calculated that its freight train crossed this same bridge safely. Unfortunately, no report was made to authorities within sufficient time to allow the authorities to notify the railroad nor was any report made to the railroad. Had either such reports been made, CSX could have imposed a stop signal or sent a radio warning to the crew on the Sunset Limited, stopping the train before it reached the bridge.

Mr. Chairman, this was a tragic accident, the worst in Amtrak's history. We are all profoundly shaken. At Amtrak, we grieve over the loss of five fine crew members and 42 passengers, and we share the grief of the families of the passengers who did not survive.

We are working closely and cooperating fully with investigators to determine the cause of this accident and to ensure that whatever precipitated this tragedy does not happen again.

Thank you. And I will be glad to answer any questions that the committee may have.

[The statement of Mr. Sullivan may be found at end of hearing.]

Mr. TAUZIN. Thank you very much.

We want to remind the Members that Mr. Cothen, Assistant Administrator of Safety, Federal Railroad Administration, is here and available to answer questions.

We all share with you this sense of grief and loss. And we also share with you a sense of responsibility to find out what went wrong and what we can do to make sure it doesn't happen again.

In regard to that, recognizing that the investigations are not complete—there is a possibility of even criminal investigations involved in this case—we, nevertheless, do not want to waste another day, before we begin repairing what perhaps needs to be repaired in the fabric of our law and regulations regarding what we already know about these accidents. And so we would like to explore with you just a little bit about that subject.

Admiral Card, your statement that the railroad bridge did not have warning lights, reflectors of any type, has been echoed by attorneys for the tugboat crew in this case. Your testimony today indicates that even if that bridge were constructed today, current law and regulations do not require it to have any warning lights, any reflectors, or any fenders to protect it again collision.

Is that the state of our law today?

Admiral CARD. Yes, it is, Mr. Chairman, as I indicated.

Of course, what needs to be marked is all under review by the Commandant in Washington. But the Big Bayou Canot is not a navigable channel. And so it is not for commercial navigation nor is it usually transited at nighttime. Those are the two things that caused it to be a problem.

Infrequently used waterways are in the same situation. The bridge has been there, as we heard, for a century, and it has not been a problem in the past.

As I mentioned, all of that is under review of what needs to happen with all of the bridges in our Nation's waterways as far as lighting and aids to navigation.

Mr. TAUZIN. So there are other bridges like the Bayou Canot which do not have lights, reflectors, or protective fenders to protect them against these kinds of situations; is that correct?

Admiral CARD. Yes, sir.

Mr. TAUZIN. From what we now know, the tug in this case apparently didn't know its actual position but continued to move and press forward in the fog. Is that customary procedure? Is that a violation of any of the Coast Guard regs in this area?

Admiral CARD. Normally, in the course of navigation, Mr. Chairman, vessels know where they are going. If they have a problem, they find a place to stop until the weather clears up.

In our collision regulation, our Rules of the Road, there is responsibility in prevention of collisions for people to be able to control their vessel within the sight that they can see.

I would say that normal navigation for vessels, they know where they are and they know where they are going. And many of the practices I have seen, when they don't, they stop and wait for the fog to clear.

Mr. TAUZIN. Is there penalty provisions to enforce those rules of the road currently in the regs?

Admiral CARD. If someone is found in violation of the rules of the road, there are penalties that go along with that.

The rules of the road are—I think the law has rules to prevent collisions at sea or in inland waters. And so they are meant mostly for the interaction between the two vessels that are coming together more than a vessel striking a bridge or something like that.

Mr. TAUZIN. Do you consider the manning, training, testing requirements for uninspected towing operators to be sufficient to prevent similar accidents like the one we saw in Mobile?

Admiral CARD. Mr. Chairman, that is probably the key element of what is being reviewed by the Commandant in Washington now. And I think it would be premature for me to comment on that at this point until that review is complete.

Mr. TAUZIN. We have been told that the investigators found no navigational charts in the Mauvilla's pilothouse. Should navigational equipment, including charts, be required on uninspected towing vessels?

Admiral CARD. Mr. Chairman, you are correct that there are none required now, and it is not part of our safety or regulatory regime. I think it is not something that we could require based upon the laws and regulations as we understand them.

And I want to be as responsive to you as I can, but the type of navigational equipment is also one of the things which is being reviewed by the Commandant, what should be on the bridges of towing vessels and what kinds of navigation equipment, radars, charts, et cetera.

And that review is not complete, and so I would need to wait until that is done before I comment.

Mr. TAUZIN. The Nation watched this accident and heard the reports of an operator who said he didn't know where he was in the middle of a fog and ends up colliding with a bridge, and we find out that he doesn't even have a chart on the vessel.

Doesn't it make sense that we ought to require the minimum aboard a vessel, including some navigational charts on that vessel and some other training for the operator to know how to use it?

Admiral CARD. I think that in our other regulations, when we address navigational safety for larger vessels and even on fishing vessels, those are the kinds of things we look at.

So I think it is perhaps consistent with what we do in other vessels in navigation safety.

Mr. TAUZIN. Would you have any opposition, the Coast Guard would have any opposition, to Congress requiring that type of minimum type of equipment and training aboard such a vessel?

Admiral CARD. I know that, as you mentioned earlier, sir, you are going to be introducing a bill this afternoon. In the normal course of business, we comment on those bills; and I am sure we will. I don't know what that position is.

Being from the Eighth Coast Guard District in New Orleans, I don't feel that I can comment on that right now.

Certainly, prudent navigation that we require for deep draft ships, and certain fishing vessels calls for certain kinds of navigational equipment on the bridges of vessels. So we have recognized that standard in the past.

Mr. TAUZIN. Mr. Sullivan has testified today that, from Amtrak's best information, the derailment occurred at approximately seven minutes before 3 a.m. Your testimony is that the first report you received, both from the CSX crew and from the operator of the Mauvilla, occurred at about 3:05 a.m.

That seems to indicate that there was a considerable lapse of time between the apparent collision between the towboat and the bridge and notification to you that, in fact, something had gone wrong.

Is there any information yet—and I will ask any of you if you can give us that information—as to approximately what time the collision likely occurred between the towboat, its barges, and the bridge?

Admiral CARD. I will say, Mr. Chairman, that our radio logs have some activity discussion going on at 10 minutes to 3 that morning, more precisely 8 minutes to 3. Of course, our first notification was at 5 minutes after 3. I don't have any more information than that.

I know that I have seen, both in the media and other things, lots and lots of different time sequences; and I think that is still being sorted out in the investigation.

Mr. REAGLE. Mr. Chairman, from the NTSB's point of view, the marine operations group is now looking at that very issue. And at some further point in time, we would have our factual findings; but at this point we don't.

Mr. TAUZIN. Mr. Sullivan, I assume you don't have any better answer for us at this time?

Mr. SULLIVAN. I don't have an answer on the time of when the boat struck.

Mr. TAUZIN. We are going to have to wait for the report of the investigation to get a fix on approximately when the collision likely occurred; is that right, Mr. Reagle?

Mr. REAGLE. Right.

Mr. TAUZIN. Given the likelihood that this collision occurred prior to the derailment of the Amtrak train, as appears to be the case, what was the responsibility of the operator of that tugboat, Admiral Card?

Admiral CARD. Mr. Chairman, we have a requirement for people to notify the Coast Guard when they are involved in a marine casualty. Our regulations provide a certain time frame for notification.

Certainly, if he knew that—if he did strike the bridge, as is speculated, and he knew about that, we normally get relatively quick calls.

But normally in the course of business, unless they have some idea of the seriousness of the event, it takes some time for them to call us. So it might be 10 or 15 minutes or more.

But there is no requirement for immediate notification to the Coast Guard for that marine casualty right now in our marine casualty notification.

If it were a bridge that were struck and it caused less than \$25,000 damage, it wouldn't even be considered a marine casualty.

That also, as I mentioned earlier, is under review by the Commandant, both the notification requirements and the penalty requirements and we're looking into it.

I mentioned in my testimony as well—

Mr. TAUZIN. What is the current requirement? And what is the penalty?

Admiral CARD. I think the current requirement is that they have to notify the Coast Guard, but I don't think there is a time requirement. I think we are talking about 72 hours in the marine casualty. And the penalty I think for non-notification is \$1,000.

We do have in our Title 33, notification of a hazardous condition aboard a vessel; but it stretches the regulations to include this sort of a situation, I think, and it is not real clear.

Mr. TAUZIN. I am going to leave it to the Ranking Minority Member to explore it further. But I am sure he would like to know what you would have done, what you should have done, what you could have done, once the Coast Guard would have received a notification timely enough to take action on it.

I want to move quickly to equipment. In regards to the equipment, Mr. Sullivan, you indicated that the equipment, the technology of the equipment is such that the conductor of the train did receive the all clear signal at some point that the tracks were not broken.

Is there technology equipment available to indicate that tracks have been knocked out of place by 3-1/2 feet?

And if so, is that type of equipment available to be installed on crossings like this?

Mr. SULLIVAN. On the technology that is available and was in the track structure at the cite of this accident, is that the signal circuit is carried through the rails itself. And if those rails are broken, the circuit is broken and the signal drops into a stop position.

In this case that did not happen.

Mr. TAUZIN. Because the rails were never broken but simply moved out of position; right?

Mr. SULLIVAN. Yes. It is possible to apply that same type of technology, say, to a bridge structure through the use of a wire or some other thing that, if it was broken, then it could be tied into the signal system to indicate there was a problem and throw the signal to stop.

But that was not in place at this site.

Mr. TAUZIN. Admiral Card, I assume that one of the topics under review, under instructions by the Secretary, in regard to bridge safety will be new technology and potential installation of that technology on crossings around the country; is it not?

Admiral CARD. Mr. Chairman, I think that is part of the review. In addition, the Coast Guard will look at results of the two accident investigations, which are being done by the National Transportation Safety Board and the results that come out of those as well.

So in addition to the review that the Commandant is doing, that will also be a part of the review. And I can only assume, as you, that the technology will be a part of that.

Mr. TAUZIN. I would hope so, and I would urge you to make sure that it is.

Mr. Cothen did you want to make a comment?

Mr. COTHEN. Just to confirm, Mr. Chairman, in keeping with the Secretary's commitment to the committee that we are reviewing

the issue of bridge alignment detection to see what can be practically done within the available technology.

For the information of the committee, railroads have deployed a wide variety of detectors for various purposes, including detectors for high and wide loads. It might strike underpasses because we have a problem of bridge displacement not only with respect to marine operations but also with respect to highway operations. Some bridges are equipped with thermal circuitry that will indicate a bridge fire and some bridges are equipped with high water detectors. And there are a variety of other detecting systems out there that are linked into the signal system, or may be freestanding.

However to, get a good bridge alignment detection that will serve you well over thousands of bridges, where that technology might be employed in the past has been viewed a relatively high cost proposition and in relation to the other risks that we encounter in rail transportation. So we are reviewing that proposition again in light of this accident.

Mr. TAUZIN. In regards to the Judge Seeber Bridge, clearly, one of the contributing causes of that accident was the fact that the operator left his station and there was no one aboard the vessel to take his place.

Is that a failure of any of our requirements on these vessels?

Admiral CARD. Mr. Chairman, I believe the manning requirements state that the towing vessels over 26 feet be under control of an operator of uninspected towing vessels. Our interpretation of that is the person is on the bridge when they do that. Because the person was not on the bridge, we considered it to be negligence, and that is the reason we charged the operator.

I think the manning requirements for operating that vessel certainly were not met in accordance with the existing law and that was part of the problem for the accident.

Mr. TAUZIN. The chair now recognizes the ranking minority member, Mr. Coble, for questions.

Mr. COBLE. Thank you, Mr. Chairman.

Admiral Card, I want to go back to the bridge a minute. I realize there was no requirements for any lights or warnings to be affixed thereto, and I also realize that this channel—I am talking about the Mobile collision now, that this channel is not a navigable channel nor is it used commercially. Are there recreational boats that use those waters?

Admiral CARD. Yes, sir, I believe there are, mostly in the daytime. There is very little operation at night, as we understand it, and so that is another reason why there were not lights or markings on the bridge, but we understand it is mostly used in the daytime for recreational vessels and not a commercial navigation channel at all.

Mr. COBLE. Let me put a hypothetical question to you, with the idea that it is too late to do anything about what we are here for, but speaking subsequently now. Assuming one of your inspectors, Admiral, came to you and said, listen, we have a lot of recreational activity in that area, I think there needs to be a light affixed to this bridge. Could the Coast Guard have done that administratively or would that have required congressional response?

Admiral CARD. I will need to do two things for you, sir. One is, I will give you an answer which I think is right. Then I will make sure I provide the correct answer for the record. Make sure we don't have that misunderstood.

I believe in our statutes right now, if we think there is a reason to light the bridge like that for some recreational reason, we could do that but—and we may in certain situations, because our goal is safety, and I think there probably is the authority to do that for safety if we believe there is a large amount of recreational traffic through that area that would call for that lighting. And what I will do is I will also check that and make sure it is correct for the record.

[The information follows:]

BRIDGE LIGHTING

The District Commander has the authority to require lights on bridges within the Eighth Coast Guard District. We exercise that authority only when there is significant night time commercial or recreational navigation past the bridge. The authority cite is Title 33, Code of Federal Regulations, 118.1 and 118.5. Copies of these regulations are attached. (See end of hearing for copies of these.)

In regards to the big Bayou Canot Bridge, we have never been contacted by any commercial or recreational waterway user about lights on this bridge. We believe there is little or no night time navigation passing the bridge.

Mr. COBLE. All right, sir. Thank you. Let me shift now to the wheelhouse of the tug. The chairman referred to the lack of charts. Do you know—I assume you know—whether or not the wheelhouse was equipped with a compass? Was there a compass in that wheelhouse?

Admiral CARD. To the best of my knowledge, sir, there was not a compass in that wheelhouse. Again, we can check that as well. I am sure as part of the investigation—

Mr. REAGLE. That is my understanding, sir.

Mr. COBLE. That there was no compass?

Mr. REAGLE. Correct.

Mr. COBLE. Thank you, sir.

Mr. Sullivan, I mentioned at the outset my concern about the delay. Actually there are two delays. One delay occurred from the time that—of the initial impact of the tug against the bridge. The second delay occurred from the time of the derailment to the initial telephone call that was taken by the Coast Guard and, Admiral, I believe you said there were two calls made to the Coast Guard.

Admiral CARD. One came from a bridge operator saying a train derailed. The second one came from the towboat. They were two different Coast Guard units, but they had communicated among themselves within the minute.

Mr. COBLE. And both reported a derailment?

Admiral CARD. The bridge-tender reported a derailment. The towboat just reported that he had lost some of his barges, he had a problem with the barges initially. He did not report that there was a derailment or a problem.

Mr. COBLE. Did he ever make a subsequent call concerning the derailment?

Admiral CARD. Yes, he did. Three or four minutes after that he indicated there was a train in the water and there was a problem.

Mr. COBLE. I thought that was right. I wanted to be sure I had that correctly.

Mr. Sullivan, again, playing with hypotheticals, looking to the future, assume in the best of all—the light most favorable to all, that once the impact occurred, immediate notification was relayed, what could you all have done logistically to have avoided the ultimate result?

Mr. SULLIVAN. Well, if the impact occurred sufficient time before the derailment to notify the bridge operator and that notification was made, he could have been in touch with—and they were in touch by a radio—with CSX's Transportation Center in Jacksonville. They could have set the signal against the train to prevent the train operating by that signal.

In addition, the train crew, both the head end, the engineer and the assistant engineer, and the conductor, have radios on the train, and so radio contact could have been made with the train that there was a problem at the bridge and the engineer could have brought the train to a stop.

Mr. COBLE. Admiral Card, let me perhaps extend that question. If the Mauvilla or appropriate people aboard the Mauvilla had immediately reported that it had struck the bridge, would the Coast Guard watch-stander or the person on watch who was taking the call at the time at group Mobile, would he or she have known to have alerted CSX or Amtrak of the danger?

Admiral CARD. Yes, sir, I believe they would. We asked them that question. They had that in their procedures at the unit.

Just to make sure of that, however, because we didn't have the same procedures all through the District, we have instituted a protocol right now where as soon as we find out there is damage to a bridge, we immediately notify the bridge owner. In this case that would have been CSX, and we have the 24-hour notification numbers; and as well, if it were a highway bridge, we would notify the highway patrol as well as the State police.

So I believe we would, but we have reinsured that, and we are testing that right now. We are testing during the day the 24-hour number to make sure it is a good number so that we could make this notification if we had the information.

Mr. COBLE. And one final question, Mr. Chairman. I think I am recalling this correctly.

I believe Admiral Card, from your statement, or maybe one of the staff—I think it was your statement, Admiral Card, and that involves the skipper or the operator of the tugboat or the tow initially responding to tie-up of the barges that at the time were adrift, and then returning to the scene to attend to the survivors of the train, many of whom were in the water. Am I recalling that correctly from the statements?

Admiral CARD. Mr. Congressman, I know that the first call we got was that the towboat was concerned about the barges that were loose, and they were paying attention to that. Our callback was, "Is anybody in danger, do you need any help?"

I am not sure of the sequence of events for all the rest of their activity, and I am sure that will come out in the investigation, but our first call was that. The second call was that there was a train in the water.

Mr. COBLE. Mr. Reagle, you may be in a position to respond to that as well.

Mr. REAGLE. What I know is just what—at this point in time, Mr. Chairman, is that is what we have read in the newspaper, but I can't confirm from that group precisely what the sequence of events was.

Mr. COBLE. Again, Mr. Chairman, I am applying 20/20 hindsight here, but I am willing to stress that unless there was imminent danger as a result of those barges that were adrift, to have abandoned those people in the water, that bothers me. Perhaps we will know a little about that as the investigation develops.

Thank you, Mr. Chairman. Thank you, gentlemen, for being with us.

Mr. TAUZIN. Mr. Reagle, when do we expect the investigation report to be completed?

Mr. REAGLE. Generally, Mr. Chairman, it takes us between nine and 12 months to do a final report that goes before the board, and the board approves both the probable cause and the recommendations. So I would expect late spring or early summer, sir.

Mr. TAUZIN. Chair recognizes the gentleman from Michigan, Mr. Stupak for questions.

Mr. STUPAK. Thank you, Mr. Chairman. I am a little confused on navigable waters versus nonnavigable.

Would you explain that for me?

Admiral CARD. Yes, sir. The waterways we are talking about, I think legally speaking, are considered navigable waterways of the United States as to who has jurisdiction over them, but this is a waterway which is not normally navigated by commercial navigation. It is also not required to be dredged or maintained by the Corps of Engineers. It is not a congressionally-authorized waterway.

For instance, the Mobile River or the Mississippi River, et cetera, are all channels which are approved by the Corps of Engineers. So this is, if you will, non-navigable to commercial navigation, although it is legally considered a navigable waterway of the U.S. and navigable waterways go all the way up to North Dakota.

There is a legal definition of navigable, but this one we would say, is not normally navigated by commercial navigation.

Mr. STUPAK. Not normally navigated by commercial vehicles, or vessels I should say. What are these boats doing here then?

If it says, if you look at the report here, one of the reports said they thought that the bridge was another barge and thought that it was going to go tie up to it. So the pilot thinks there is another one there in these nonnavigable commercial waters. I guess I am really confused.

Admiral CARD. Sir, I think all that is a part of the investigation. Someone operating in Big Bayou Canot with a tugboat is not normal.

There may have been somebody that goes up there from time to time to park but for no other reason. That waterway is a 90 degree turn from the main channel. As you are coming up the Mobile River to go into the Big Bayou Canot, you have to turn about 90 degrees to port to get into that waterway. So there is nothing up there for anyone to go to, there is no reason to go there, and of

course you have a bridge across the area. So it just isn't a normally navigated place for commercial vessels. They may from time to time tie up there, but I don't think that is normal practice either.

Mr. STUPAK. Is there any requirement for this operator to—it indicates in one testimony that it was going to begin a three-day journey up the river. Does he report in any kind of a plan, I think of airplanes, a flight plan, a boat plan or anything like this as to his route, where he expects to go?

Admiral CARD. There is nothing that I am aware of in the regulations which requires that. This was probably considered a standard operation, with the number of barges they had. There were two operators, one is called the captain, one is called the pilot.

The captain who was the most senior of the two usually works from 6:00 o'clock at night until midnight. The pilot then picks up from midnight to 6 o'clock in the morning. They stay on that watch routine while taking those barges up to Birmingham, probably something that they had done many times before. Maybe not these people, but that company surely does, and it is a standard operation up the river.

Mr. STUPAK. What criteria does the Coast Guard have, or whoever in the Army Corps, to determine whether a waterway is commercially navigable? How do you make that determination?

Admiral CARD. In the rivers and the harbors and almost all those channels that I am aware of, it is part of the Corps' budget, and it is authorized by Congress for that to be a navigable channel. They authorize the width and the depth and then it is maintained. The Coast Guard marks those channels with aids to navigation to make sure the mariners can use the channels. That is the standard that I am aware of for a navigable channel, and they are so marked on the charts that way.

Mr. STUPAK. Mr. Reagle, you indicated that evidence of the two most recent accidents indicates that more can be done, that positive work has been accomplished in these areas, but more can be done. You end your testimony that way. What would you suggest be done?

Mr. REAGLE. Well, I think there are a lot of areas, sir, that we are exploring. For example, last week in New Orleans, we had a hearing on the accident, and I mentioned on that, I mentioned on the Judge Seeber Bridge and in that hearing we looked at two issues, pier vulnerability and then once a risk assessment is done, pier protection, and the issue of bridge inspections.

I think those are two big issues the board has been involved in for some period of time, and as I mentioned in my testimony, I think 1972 was the first accident.

I think there are some other areas. Certainly the whole area of human factors. Some of the issues the chairman is looking at: licensure, knowledge of local waterways, those kinds of things I think are important. Navigation aids, vehicle barriers and warning devices, all of those, I think, we are talking about a systemic problem that we need to look at and certainly when the board does its investigation, it is very comprehensive and we do look at it in a systemic way, but I think from our investigation and our hearing last week, two major issues, as I mention, appear: vulnerability and bridge inspections.

Mr. STUPAK. OK. Admiral Card, the tug here did not even have a compass. Is that something that is very fundamental to a commercial operation if you are operating a commercial vehicle?

Admiral CARD. In most cases, it is. In some of the rivers where they go up and down, there are not many other places to go, it is perhaps not as useful as it is in an open bay or whatever, but mostly it is, sir.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. TAUZIN. Thank you, Mr. Stupak.

The chair recognizes the gentleman from Mississippi, Mr. Taylor, for questions.

Mr. TAYLOR. Thank you, Mr. Chairman. Admiral Card, what is the rule of the road for operating with restricted visibility or fog?

Admiral CARD. The best I can remember, sir, is that you need to be able to effectively control your vessel so that you don't run into another vessel. That is the idea. You should be able to stop within your own length so that you can see.

In other words, if you can only see 200 feet, you ought to be able to stop within that length to make sure you don't run into something else. I am paraphrasing that. There are more legal terms than that and we can provide that, but that is generally the rule.

[The information follows:]

RESTRICTED VISIBILITY NAVIGATION

Until 1980, the Navigation Rules contained language which stated that vessels underway in restricted visibility shall proceed at a "moderate speed." (Article 16, Inland Navigation Rules, CG-169)

In his book *The Law of Tug, Tow and Pilotage*, Alex Parks traces the history of the term moderate speed and its definition. The courts first developed the "half distance rule" in an 1890 case before the Supreme Court. Over time the standard of care became that a vessel be operated in a fog at a speed which is not so fast that she cannot stop within a distance her helmsman can see ahead. Assuming that other vessels were also traveling at moderate speed, the "half distance rule" is also described in a similar fashion in the *Law of Admiralty* by Gilmore and Black.

In 1980, the Navigation Rules in Title 33 U.S.C. were amended to state that vessels navigating in restricted visibility shall proceed at a "safe speed" vice "moderate speed." Safe speed is the speed necessary to avoid a collision. Title 33 U.S.C. 2019, along with the Inland Navigation Rules published by the Coast Guard, specify that in restricted visibility vessels that detect another vessel by radar alone shall take action in ample time to avoid a collision.

Mr. TAYLOR. If I am not mistaken, it might even be half visibility is your stopping distance.

In response to some of Mr. Tauzin's suggestions, before we go into mandating more equipment, wouldn't you say it is important that the operators know how to use the equipment they have on board now? In particular, was the vessel operator required to pass some sort of a radar test in order to be licensed?

Admiral CARD. The licensing procedure does not include a radar test for the operator of uninspected towing vessels. There are navigation questions, there are safety questions, there are rules of the road questions, but there is no requirement for radar.

For the larger vessels, the licensed people are required to go to a radar school and pass that test, but there are no radar requirements for an operator of uninspected towing vessels.

Mr. TAYLOR. I am sure in your career you have been on the larger vessels where you have the luxury of a quartermaster read-

ing courses off to you who is sitting at a plotting table when you are in an open body of water, but quite frankly, a compass and a chart in a restricted waterway, like a river, where you have currents that are at different speeds at different times of the year, that are bending, quite frankly a compass and a chart aren't nearly as important as radar, are they?

Which leads me to my next question, Admiral, since we both know the answer to that because I have seen from your resume that you have operated vessels in restricted waters. Why then does not the Coast Guard require the operators, especially since that has become their eyes nowadays, to have a radar endorsement?

Admiral CARD. Mr. Congressman, we are looking into that. I think as we mentioned, that is a part of the review, what kinds of qualifications should they have and I am sure that the radar qualifications and the ability to be able to operate is a part of that review and we will provide those answers to you when we have them.

Mr. TAYLOR. Admiral, I want you to comment on this. The way I see it, we had four screw-ups, and I think they were in this order.

Number one, the vessel operator was operating faster than he was able to stop within one-half the distance his visibility.

He didn't understand how to use his radar. If he had understood his radar, he would have clearly seen the sides of the river by turning his gain up and he would have seen the bridge going across, so I think those are the two biggest contributing factors, which could have been prevented, incidentally, had that operator been required to pass a radar test.

But the third thing is, as Mr. Tauzin has pointed out in this and as I will submit to the record, this has happened before on that river. Earlier in this century, another towboat knocked out that same bridge and the locomotive engineers were the only ones who died because back then the train was only going about 20 miles an hour and the passenger cars did not fall in, but there actually was a photograph of one of the passenger cars dangling over the bridge very similar to this one.

So it has happened, Admiral, and the fact of the matter is, we are both familiar with the shallow water down in the southern part of our country, and to call 27 feet of water unnavigable is silly. Intercoastal waterway is only 12-foot deep and any place that you can fleet barges ought to be considered navigable because that is the way the towboat operators are.

Any place they can stick them when they are waiting or fog-bound, they are going to stick them, and I think the Coast Guard screwed up. I think that bridge should have been marked and, quite frankly, Mr. Sullivan, I think the 4th—and again in the order of things that went wrong, is obviously your system doesn't work. A bent rail, a rail out of place is just as dangerous as a broken rail, and obviously something needs to be done to change what you are doing because what you have doesn't work.

You had a rail that was bent so badly that a very slow freight train could make it across, but not a 70-mile-an-hour passenger train and that needs to change and it is a shame it took this accident to bring these things to everyone's attention, but in the case

of the unmarked bridge, Admiral, it has happened in this century, and it just shouldn't have happened again.

I would like you to comment on that.

Admiral CARD. I have no knowledge of the previous history. And let me just say, Mr. Congressman, that if the fog we are talking about is as thick as you are mentioning and the person couldn't have seen the head of the tow, they probably wouldn't have been able to see the lights on the bridge either. That is something we need to look into, but he might not have been able to see.

Mr. TAYLOR. He was breaking the rules of the road, wasn't he? The fact that he didn't even know he hit the bridge told me he couldn't have stopped within one-half of visibility because he couldn't even see the bridge. He didn't—he either is not being honest with the public in saying that he didn't know what happened or he didn't see the bridge, and if he didn't see the bridge, then he obviously was operating too fast to stop within one-half of his visibility, and that is a violation of the rules of the road and that is a violation of the present rules.

The second thing is, he obviously didn't know how to work his radar or it wasn't working properly or both, because he would have seen the outlines of the banks of the river and very clearly seen that bridge on his radar had it been operating properly.

Is that correct?

Admiral CARD. Obviously, something went very wrong here. Every indication is that he hit the bridge, that the bridge was out of alignment, we had a terrible accident. All the different pieces that went into this thing, I think, Mr. Congressman, what you are mentioning probably are part of those, but I don't know all the intricate things. I think it is a complex series of events that are being brought out in the investigation. We will know those answers, I hope, when the investigation is complete.

Certainly something went very wrong. It easily could have been the radar thing, could have been navigation concerns or other things which we are looking into at this point, but certainly something went wrong. It didn't work the way it should have.

Mr. TAYLOR. Getting back to a problem with enforcing the present rules that are leading to some of these accidents: in the case of the towboat Chris, "ves" one of the engines, one of the vessels's engines was running but you didn't have anyone on the pilot-house. It was not made fast to the shore.

If I am not mistaken, that actually requires a line or an anchor, so once again, one of the rules was broken; wasn't it? And no compass or chart would have changed that. That was just a fact that one of the rules that are presently required to be lived by was not being followed.

Admiral CARD. Mr. Congressman, I think that you will see, nosing into the bank, which is effectively running aground along the bank is a standard procedure for towing vessel operators. I think that what was not standard in that case was for the operator to leave the bridge of the towboat to go down below. Had he stayed on the bridge, chances are, they never would have had the problem.

It is also under investigation, but it seems to be a simpler series of events than over in Mobile. Because of the facts we knew in that

case, we brought the charges against the operator. But there is no requirement to tie-off against the bank or to drop an anchor. The requirement is to maintain control of your vessel, and had he stayed on the bridge, like many others do in that area waiting for the canal to open up, he probably would not have had a problem.

Mr. TAYLOR. My last question before my time expires, Admiral, would it take legislation for the Coast Guard to change the requirement for licensed operators to require a radar endorsement, or can the Coast Guard do that themselves?

And can, say, you differentiate between your smaller five-ton licenses, your 50-ton licenses, your hundred tons?

At what point do you require a radar endorsement?

Admiral CARD. Mr. Congressman, let me answer both your questions as I understand them.

First of all, does the Coast Guard currently have the authority under the law which requires us to have licensed operators on towing vessels to change the requirements for that? I think there must be some latitude in that. I don't know all the details of that, and it is being looked into.

Second, when do we have to have a radar operator's license on board a vessel? I believe it is if you are operating a vessel more than 300 tons, near coastal waters or the ocean, is where you have to have radar on board, and a radar endorsement on your license. I may have the breakpoint off a little bit, but that is effectively what it is. You need to go to school, get that certificate and have that to be able to operate on your license.

But not for inland. For inland waterways, we have towboats as big as 2,000 gross tons, which are not required to have radar or not required to have the radar endorsement either.

Mr. TAYLOR. Doesn't make much sense, does it?

Admiral CARD. We are looking into that, sir.

Mr. TAUZIN. Would the gentleman yield?

Mr. TAYLOR. Sure.

Mr. TAUZIN. Just to make it clear, he has put his finger on something that we also identified, and the legislation we will offer will contain specific authority for that requirement in licensing, and I think you have it already.

Admiral CARD. I think we do too, sir.

Mr. TAUZIN. You better make doggone sure you have that authority, because as the gentleman indicated, even with a chart, even with a compass aboard, it wouldn't have helped him much in the fog if navigational aids are not followed and the operator can't even operate his radar properly.

Admiral CARD. Sir, I think we have the authority for licensing. I don't think we have the authority right now to require radars on towboats on inland waterways.

Mr. TAYLOR. I yield back.

Thank you, Mr. Chairman.

Mr. TAUZIN. Thank you, Mr. Taylor. The Chair now recognizes the gentleman from Kentucky, Mr. Barlow.

Mr. BARLOW. Thank you, Mr. Chairman. Thank you for holding and organizing these hearings so rapidly after this heart-wrenching tragedy down in the Gulf. I know that the Amtrak structure is very intent on safety and has a remarkable record of safety consid-

ering the miles traveled every day and the numbers of people that are transported every day, and I am very proud of Amtrak and the growth that you all have pressed within our nation in the last few years.

Just on this situation, I am wondering if there is technology here that may be available of a sensory nature that could show if there was damage ahead and signal it to the cab, thinking in terms of the navigation aids too. We have the bridges going across these bayous and rivers throughout the United States. We used to have fog horns. I guess we have gotten away from fog horns in recent years. Is that true?

Admiral CARD. In certain locations, Mr. Congressman, there are fog horns. I happen to have recently come from Seattle, Washington, and I lived in a place where there was a Coast Guard light in the Puget Sound and there was a fog horn on that light. So there are horns. The technology for how they operate has changed. They are more electronic now than they were, but we have fog horns around the country.

Mr. BARLOW. Might there be some type of a signal that would be picked up by a very simple receiving device, say in the cab of a towboat, indicating that there was a bridge there, just a beep, beep, beep? Maybe we have gotten away from the old fog horns that blasted in the night for social reasons or reasons of maintenance, the expense of maintenance, but might there be something on the bridge that would just be a simple electronic beep coming off the superstructure at some point, that would be picked up just as a kind of a signal, almost a radar signal—on the towboat so that where we have got these heavily traveled passenger rail routes, there would be an alert going out constantly 24 hours a day that this was a very sensitive object that was coming up here?

Admiral CARD. Certainly, sir, that kind of thinking is a part of what both the Coast Guard and the Department of Transportation are looking at to see what needs to be done.

Now, these accidents have brought that to light. So what you talk about I think is—the technology is available. The question is, do we want to do that? But they will be looking into that as part of the overall review.

Mr. BARLOW. It could be done relatively inexpensively, couldn't it? I mean, radar is passive. You are reaching out there with a signal and the configuration is coming up that is really not showing you everything that might be of concern here. Here is not just an object which evidently the towboat operator reads as possibly being another line of towboats that he could yoke up with, but that this would be an object that is of very special significance and with just an electronic beep that is coming into some very simple little receiver in his cabin, that he is hearing audibly and he is saying to himself as he is steering through this maze of fog or night or whatever the conditions are, we are coming up on something that is—I have got to be very cautious with—is that a possibility?

Admiral CARD. Sir, it is. That sort of technology is used in other places around the country where there were racons, things which beam out signals, so it is available. Again, it will be a part of the

review to determine what type of markings or navigation aids, et cetera, we need for these kind of things.

Mr. BARLOW. When the tow hit the bridge, did it hit a pier or did it hit the bridge itself? I am reading in the testimony here that the bridge itself was only seven feet above the water.

Did it hit the bridge itself or did it hit a pier that was actually supporting the bridge that was in the channel?

Admiral CARD. I don't have knowledge of that right now, sir. Perhaps the accident investigation people could tell you that.

Mr. REAGLE. I think preliminarily, what I understand, Congressman, is it hit both, or that is what we are looking at, yes.

Mr. BARLOW. How many bridges are there? There are thousands of bridges over water courses, over rivers, over estuaries? Narrowing this down where we have bridges that are high enough that boats can pass under them, these might not be of nearly the significance as where we have bridges right down close to the water. Would that be right?

Mr. SULLIVAN. I would say, Mr. Barlow, that we have to be concerned about all bridges because even if the bridge is very high, it has a pier usually that is in the water and that can be struck, so we have to be concerned about all types of bridges, I believe.

Mr. BARLOW. Well, where it is on a pier, if it is a high bridge on a pier, or even a low bridge on a pier, will there be consideration given to buffering structures around the pier? I have seen them from trains going up along the Atlantic coast, there was a gabion or whatever buttressing out from the bridge that is filled with rock. That will be considered, I would imagine—is that right?

Mr. SULLIVAN. Yes. Usually in navigable waters, the bridges, the main bridge pier is adjacent to the channel and protected by what you described or by a wooden structure that would deflect a boat that was going toward the pier and steer it back into the channel, and those are on bridges usually in navigable waters.

Mr. BARLOW. Thank you, Mr. Chairman.

Mr. TAUZIN. Thank you, Mr. Barlow. In fact, Mr. Sullivan, in the Judge Seeber case, it was a support column that was struck, was it not, Admiral?

Admiral CARD. Sir, it was the main navigation span. The piers were heavy and protected. It was off more to the land side and it was a fairly thin column that was holding up the bridge, but it took no lateral damage from the barge.

Mr. TAUZIN. And so we can't allow any of these bridges to escape our attention, I take it.

For the record, a couple things. Mr. Sullivan, you testified that the Amtrak surviving operators tested negative for drugs or alcohol.

What is the case for the operator of the tugs? Mr. Reagle? Admiral Card?

Mr. REAGLE. I can supply that for the record. I am not aware—

Mr. TAUZIN. I understand there was a test the day before and there was a toxicology test taken some hours after the accident; is that correct?

Mr. REAGLE. Something like seven hours after.

Mr. TAUZIN. I believe it was nine hours, and the question I want to ask you is why so long?

Admiral CARD. Mr. Chairman, I think the regulations require that the employer test for drugs and alcohol after there is any accident within a certain time frame. I can't tell you why it took so long but in New Orleans at the Judge Seeber Bridge, there were quicker tests than over in Mobile. There was no indication of there being drugs or alcohol involved.

Mr. TAUZIN. Both were negative, I understand.

Admiral CARD. Both were negative. The timeframe as to why it took so long to get the test done is going to come out in the investigation. I don't really know the answer to that question.

Mr. TAUZIN. We have got some real timeframe issues here. When the current law says the operator of a tugboat doesn't have to notify you for 72 hours, something is badly missing. Time frames allowed for testing toxicology results allow for nine or 10 hours and something must be missing there, too. I understand we had the similar problem with the Exxon Valdez, if you recall.

Admiral Card.

Admiral CARD. I wanted to correct myself a little bit, Mr. Chairman, on the notification requirements, because what the regulations say is that they are supposed to notify, as soon as possible, the Coast Guard's Marine Inspection Office whenever a casualty involves any of the following, and then it goes through a whole litany of things.

Then it goes on to talk about having to send a written record to us. If the written record comes in delayed, that can also add to notification time. But 72 hours is not in the regulations and so that was my interpretation and that is probably not correct.

Mr. TAUZIN. So it is as soon as practicable.

Admiral CARD. As soon as practicable.

Mr. TAUZIN. Is this accident covered in the long list of things?

Admiral CARD. The way it would be is if the operator thought that he had done more than \$25,000 damage to the bridge or to himself, so it may not be covered. Again, that is one of the reasons for all the investigations.

Mr. TAUZIN. So we may have a problem here in the regulations that need some work?

Admiral CARD. That is correct.

Mr. TAUZIN. Obviously you have authority to correct that on your own, right?

Admiral CARD. We have the authority to correct that; yes, sir.

Mr. TAUZIN. Was the entrance to the Big Bayou Canot adequately marked with aids to navigation? You talked about it being a 90 degree turn. Were there any indication indicating that this was a nonnavigable waterway?

Admiral CARD. The aids to navigation in the area, Mr. Chairman, guide the vessels up the river. There were no navigational aids that guided anyone in or out of Bayou Canot because it is not normally navigated. The aids that are there, and I reviewed them yesterday with the Group Commander, Captain Bert Kinghorn, and his aids to navigation people, are three or four aids within about a mile-and-a-half which help someone operate around the 12 Mile Island and up the Mobile River, and those are the aids that were determined adequate.

We are reviewing that, but there is no aid that would help anybody in or out of the Bayou Canot.

Mr. TAUZIN. Go back to what the gentleman from Mississippi said. This is not the first time an operator has gone up Bayou Canot, not the first time it has collided with that bridge, not the first time an accident has resulted.

Mr. TAYLOR. Mr. Chairman.

Mr. TAUZIN. Yes, sir.

Mr. TAYLOR. If I could correct myself, Admiral. I was mistaken. There has been an accident before. The previous accident was when the draw had been left open and the train almost landed on a tug at that time. The tug did not hit the bridge but there was a previous accident on that bridge in 1931.

Mr. TAUZIN. That was when it was in an open position then. But nevertheless you had a tug in that canal at that time. It seems to me that one of the things I hope you will do is examine whether or not aids to navigation are adequate to assist operators in those foggy conditions to know when an opening to a channel is not a proper opening. It is simply having aids to navigation up and down the proper channel may not be adequate in this instant and I wonder if you are going to review that.

Admiral CARD. That is part of what I mentioned earlier. When we look at all our waterways in that area, we do what I call the WAMS study and we are in the process of redoing that study right now in that area so we are looking into that. We certainly will.

Mr. TAUZIN. Let me again thank you all. You have added immensely to our understanding.

The gentleman, Ranking Minority member, has one final question.

Mr. COBLE. Thank you, Mr. Chairman, and I will be very brief. Mr. Reagle, did you say that it would require between nine and 12 months for you to have your completed investigative report?

Mr. REAGLE. Yes, sir.

Mr. COBLE. I realize you don't make the law, but—and I also realize that these investigations need to be thoroughly and deliberately conducted.

Mr. REAGLE. Right.

Mr. COBLE. But my gosh, Mr. Reagle, take back to the bosses—let's accelerate it a little bit. I mean, I think nine to 12 months is an unduly long time, and I would like to—like I say, I don't want to sacrifice quality investigative procedures with accelerated meter-running, but let's look to see if we can't do a little better than that.

Mr. REAGLE. We would certainly try. Let me say that for every major accident investigation we do, whether it is in the aviation area or in surface transportation, those accidents generally take six months or longer and we will certainly try on this one to accelerate it.

Mr. COBLE. Thank you, sir.

Thank you, Mr. Chairman.

Mr. TAUZIN. One final thing. I think it is important to note something in Admiral Card's testimony today, and that is that there was a prior drill which aided immensely in coordinating efforts in this disaster relief. I hope the investigation will also highlight that

kind of drilling would be useful in other parts of the country where, in fact, these incidents do occur.

The final thing I wanted to comment concerning Mr. Sullivan's testimony with reference to the improved braking systems at Amtrak. Obviously new technologies could probably have saved some lives in this incident. I wonder whether or not we may be missing other technologies that could be saving lives, such as, ge positioning, satellite navigation systems. GPS would have told the tug pilot his position on the Big Bayou Canoy. Our bill will investigate the potential of GPS on the Inland Waterways.

So we thank you for the contributions you have made today. We will not wait eight, nine months, Mr. Reagle, for reports of the investigation. We simply can't afford to do that. Obviously we see some holes that need plugging immediately. We are going to try out some legislation.

We are going to have some more hearings on that legislation. We will call upon the Commandant, Amtrak, the Department of Transportation, and the Safety Board to assist us as we deliberate that legislation. Perhaps we can do some things now. Perhaps we can make it clear that radar training is necessary on the inland waterways.

Perhaps we can make it clear that at least you ought to have charts and compasses aboard on your vessel. A chart would have told the pilot that there was a railroad bridge up there, and we ought to have people on board that understand the rules of the road and understand how to man a vessel when the engines are running.

We simply have to move within the time allotted to us to plug some of these holes. We will be doing that if we can and we will ask your assistance as we move forward in plotting that effort.

Thank you, gentlemen.

Mr. TAUZIN. We will now convene the next panel.

The second panel will give us a look at the inland towing industry from the viewpoint of the American waterway operators, represented by Mr. Thomas Allegretti. Mr. Allegretti is, by the way, incoming president of AWO replacing Mr. Joe Farrell. So it will be up to Tom Allegretti to manage the affairs of the American Waterway Operators for the coming year.

He will be accompanied by Captain Jerry Tinkey, Vice President of the Operations for Ingram Barge Company and the panel will also be represented by the National Director of the Political Action and Governmental Relations Secretary of the Seafarers International Union, Mr. Terry Turner.

Gentlemen, your written statements are, by our rules, part of the written record of this hearing. And we would appreciate your summaries so that we might get into questions and answers as quickly as possible. We will start with Tom Allegretti.

Tom, welcome and bon voyage on your new assignment.

STATEMENT OF THOMAS A. ALLEGRETTI, SENIOR VICE PRESIDENT, OPERATIONS, AMERICAN WATERWAYS OPERATORS, ACCOMPANIED BY JERRY TINKEY, VICE PRESIDENT OF OPERATIONS FOR INGRAM BARGE COMPANY; AND TERRY TURNER, NATIONAL DIRECTOR, POLITICAL ACTION AND GOVERNMENTAL RELATIONS, SEAFARERS INTERNATIONAL UNION

STATEMENT OF THOMAS A. ALLEGRETTI

Mr. ALLEGRETTI. Thank you for your nice remarks, Mr. Chairman.

Good morning, Mr. Chairman, and members of the subcommittee. My name is Tom Allegretti and I am currently Senior Vice President of Operations for AWO. I am joined today by Captain Jerry Tinkey, who is Vice President of Operations for Ingram Barge Company. Captain Tinkey has joined me in order to help us be responsive to any questions you have that relate to the operation of vessels.

We appreciate the opportunity to be here this morning. We have submitted more extensive testimony for the record, and I will summarize its essential points for you here verbally.

Before I begin, though, I do want to say that our industry has deep sorrow at the tragic loss of life which resulted from the Amtrak derailment last month, and you can imagine that our sadness is compounded by the fact that our industry was involved in that tragic event.

Let me begin by saying that we applaud the speed with which you have begun this inquiry, Mr. Chairman, and the equally quick action that has been taken by the Secretary of Transportation and the Coast Guard Commandant. Our industry shares your objectives of insuring a complete examination of the circumstances of the Amtrak derailment and learning whatever lessons it may hold for us in terms of the operation of vessels.

The most important message I can convey to the subcommittee this morning is this: if the accident investigations now underway uncover any system-wide inadequacies in the way that vessels are operated, you can count on us to be in the forefront of seeking to define and implement solutions as a constructive partner with this subcommittee and with the Department of Transportation.

We would be pleased to work with you, Mr. Chairman, on the legislation that you are introducing this afternoon. We share the sense of responsibility that you mentioned earlier and we must all work together to assure that nothing like this ever happens again.

I must also say that it would be inappropriate for us to comment on or speculate about the accident itself. The investigations continue, as we heard here this morning, and we should await their results before drawing any conclusions of a permanent nature. However, once those investigations are complete and once all of the data is before us, we look forward to joining you in constructively finding solutions to these problems.

The hearing today focuses on the safety of our industry, at least that part of our industry which operates on the inland rivers, and I can tell you without fear of contradiction and certainly with all sensitivity to the human tragedy that took place in Alabama, that safety is a deep and abiding objective in this business. Our compa-

nies pursue safe operations because it is the right and the moral thing to do and because it is sound business practice.

The consequences of unsafe operation for a barge line range from loss of life to enormous liabilities, to government penalties, to lost business opportunities, and anyone who hopes to survive, let alone prosper, in today's business environment, just can't afford that.

That is an assertion which is borne out by a couple of things that are noteworthy. The first is the numerous measures which our companies have instituted at their own initiative and in concert with their shipper partners to enhance the safety and the quality of their operations. These include increased focus on personnel training and the establishment of rigorous standards for personnel selection.

In addition, companies in our industry have embraced the quality movement which has taken root in so many of America's successful corporations and have established quality partnerships with the shippers that they serve.

Our commitment to safety is also borne out by government statistics. Barge transportation has the lowest probability of an accident among all modes of transportation and is statistically the safest mode of transport, both in absolute number of accidents and in lives lost.

While we wish to impress upon the subcommittee today our commitment to safety and our good safety record, I do not want our message to be misinterpreted. It is not that we are perfect or that we can't do any better. We can do better and we are trying. We are well aware of the fact that as long as there is one accident, one injury, one casualty, we must continue to improve, and we don't need to be sold on that objective.

As you know, Mr. Chairman, our industry considers personnel competence to be the linchpin in its continuing efforts to ensure that we maintain our position as a safe mode of transportation. Thus, we believe the work of this subcommittee in the specific areas which Secretary Pena directed the Coast Guard to examine are appropriate—are prudent and appropriate initiatives under the circumstances, and we will do whatever we can to assist the Coast Guard and the subcommittee in their analysis.

We also believe that personnel competence and attention to training are issues which deserve the attention of both government and industry jointly. The governmental side of that equation is already manifested in the requirements and activities that are germane to your inquiry.

They include the fact that the individuals who pilot our vessels are experienced and licensed as required by existing statute and Coast Guard regulation. Also germane to the inquiry are the OPA 90 Coast Guard studies evaluating crew competence and modernization of the STCW convention. Those matters are addressed more fully in our testimony.

While these governmental activities seek to assure and promote safety, the towing industry of its own accord and without external prompting is moving forward with broad-based safety initiatives of its own. For example, many towing and barge companies increasingly require training for their entry level deck personnel. Some companies have established in-house training programs which

employ a mix of classroom and on-board training. Others send their new hires to outside institutions to be trained.

Meanwhile, on-the-job training, which has been a historical mainstay of our industry, continues to remain widespread. Additionally, the Towing Safety Advisory Committee is now working on an analysis of training standards for entry level personnel for the Coast Guard. An expert group of industry, labor, government and training personnel has been comprised to evaluate whether uniform entry level training requirements make sense from a safety perspective and whether there is an appropriate governmental role in their establishment.

They are currently conducting a comprehensive assessment of this matter and expect to report to the Coast Guard by the end of the year. We believe it is important for the members of the subcommittee to also be aware that this commitment to quality personnel is not one of recent vintage. AWO has been in the forefront of calling for more rigorous requirements where we believe that there is a governmental role in establishing such requirements.

For example, when the Coast Guard announced its plans in 1992 to begin a rulemaking on the certification of seamen, AWO came out in favor of new physical standards and new training standards for these mariners before the Coast Guard proposal was released. We did so to assure that the agency knew it could count on our support for increased requirements before the proposal was actually drafted.

Thank you for the opportunity to address the subcommittee this morning. We are prepared to contribute in any way we can to defining effective solutions to any problems which are uncovered in these two very tragic accidents and I will be happy to take any questions that you may have.

[The statement of Mr. Allegretti may be found at end of hearing.]

Mr. TAUZIN. Thank you, Mr. Allegretti. We will now hear from Mr. Terry Turner, National Director of the Political Action Government Relations of the Seafarers International Union.

Terry.

STATEMENT OF TERRY TURNER

Mr. TURNER. Mr. Chairman, I hope you will indulge my hoarse throat here in morning. I have been invaded overnight by the head cold.

Mr. TAUZIN. We had a similar invasion over at my house.

Mr. TURNER. Mr. Chairman and members of the subcommittee, I am Terry Turner, Director of Government Relations for the Seafarers International Union of North America, AFL-CIO, representing thousands of seamen and boatmen employed on U.S. flag vessels engaged in the international and domestic trades. I appreciate the opportunity to appear before you today to address two recent tragic incidents which have led to an untimely and disastrous loss of life and to determine what can be done to prevent such tragedies from recurring.

In the last two weeks, we have unfortunately witnessed the tragic and senseless deaths and injuries which resulted from the

derailing of the Amtrak Sunset Limited into the Bayou Canot outside of Mobile, Alabama. As you know, investigators believe that a wayward barge struck and weakened a railroad trestle shortly before the disaster which took the lives of 47 people.

The accident is still under investigation as many significant questions and crucial conflicts in evidence and witness accounts remain unanswered.

The four crew members of the tugboat, the MV Mauvilla, which pushed six barges laden with steel, coal and wood chips into the unnavigable Bayou Canot have been interviewed by the National Transportation Safety Board in the presence of their attorneys. According to the interviews, the pilot and one deckhand were on watch while the captain and second deckhand were asleep.

The deckhand who is the same watch as the pilot was sitting in the mess room when he felt a thud about 2:45 a.m.. Although all four members are charged with navigating responsibilities and must work together as a team, the captain and the pilot are the only members of the crew that are required to hold a Coast Guard license. Neither deckhand was documented, nor are they required to be. As a result, their work habits and personal history are not subject to the same scrutiny by the Coast Guard as those mariners who are required to hold documents or licenses as a basis for employment.

The second accident occurred at the end of May when a barge, the DM 30-21, struck the four-lane Claiborne Avenue Bridge in New Orleans, sending two cars and a 200 foot chunk of the structure into a shipping canal 45 feet below. One pregnant woman was killed and two men injured. The accident left one of the men, who is still hospitalized, a quadriplegic.

The accident remains under investigation. No one knows what caused the barge to crash into the bridge. Media reports quote crewmen as saying that the empty barge drifted free from the bank where the tug had stopped for engine work. The National Transportation Safety Board held a two-day hearing on this accident in New Orleans only last week.

Although most tug-barge accidents are not highly profiled or garner much media attention as in the accident involving the Amtrak's Sunset Limited, they do point to hazards of shipping on the Nation's inland waterways. As reported in the Mobile Register, more than four times a day, 1,600 times a year, barges are involved in an accident. There were 11,586 accidents involving tanker and freight barges between 1983 and 1989.

Statistics also show that 2,418 bridges were struck by commercial marine vessels between 1981 and 1990. From these figures, it appears that the degree of safety in tug and barge commerce needs to be addressed before we again are faced by another disastrous incident.

For the last two years, the SIU has insisted that a potential for catastrophe exists on the Nation's inland waterways. No longer is this prophetic. The Sunset Limited has made it all too real.

At the same time, the SIU has forcefully asserted that operational crews on inland waterway vessels have an intense responsibility for safety of these vessels, their crews, the environment and the public at large that share these waterways. Yet, something went

very wrong. As has been alleged, a barge pushed by the tug MV Mauvilla struck the bridge and may have possibly caused or contributed to this tragic accident.

As a result of this tragedy, many tenable questions have surfaced concerning the activity of the crew aboard the vessel prior to the accident. Hopefully, these questions will be answered and culpability determined when the National Transportation Safety Board and other investigatory bodies complete their probe and publish their report. However, as we are all well aware, an inquiry of this magnitude and complexity will take time. Meanwhile, tugs and barges and their crews will continue business as usual.

Even though no finding of probable cause will be made until the investigation is completed, the Secretary of Transportation has directed the Coast Guard and the Federal Railroad Administration to examine existing and proposed safety programs to ensure that we are prepared to take any necessary actions to prevent, insofar as possible, a recurrence of this type of accident.

As we understand, the Coast Guard will review the adequacy and effectiveness of the licensing requirements for operators of uninspected towing vessels, the history of accidents involving operators of uninspected towing vessels, and the adequacy of the requirements for reporting of marine casualties and hazardous conditions involving vessels and the adequacy of the penalties for failure to report such incidents.

Although we certainly welcome such a review, the SIU believes that the history of incidents on the inland waterways should also include a differentiation between those caused by documented versus undocumented crew members. The SIU further advances that one of the first steps to begin to improve safety on vessels plying the Nation's inland waterways is for Congress to require and the Coast Guard to issue merchant mariners documents to individuals who desire to obtain employment on vessels within the inland waterborne trades.

Furthermore, we must emphasize that the Coast Guard has no authority or oversight over undocumented seamen. Unlike seamen in the deep sea sector, crews employed on tugs, tow-barges and off-shore supply vessels on the inland waterways are not required to hold mariner documents as a basis of employment.

If these individuals were indeed required by statute to obtain these documents, the Coast Guard would have the authority to revoke or suspend the documents for cause, thereby precluding unfit mariners from employment in this or any other commercial maritime sector. Without some form of the fundamental entry level—without some form of fundamental entry level document, there is no way that the Coast Guard can prevent the reemployment of undocumented workers who cause accidents. It is that simple.

The first step to alter this situation lies in the hands of the subcommittee. As you know, legislation requiring the documentation of merchant mariners employed on the inland waterways was a subject of consideration during hearings held last month by this subcommittee. A similar bill passed the House last session. Unfortunately, the Senate failed to take action on the bill prior to the adjournment of the 102nd Congress.

We have debated the merits of merchant mariners documentation legislation for several years. Once again, a serious accident has brought to the forefront the need to upgrade the safety requirements of tugs and barges and their crews on the inland waterways.

H.R. 1915 can be a first step to reach the worthy objective. It is a simple and uncomplicated legislation and certainly not punitive with respect to vessel crews. Still it will add an appreciable measure of safety to this segment of the maritime industry. We cannot and should not relegate this legislation to oblivion only to be revived with the occurrence of still other serious accident which may command more costs in lives and damage to the environment.

Thank you very much. Mr. Chairman.

[The statement of Mr. Turner may be found at end of hearing.]

Mr. TAUZIN. Thank you very much, Mr. Turner. I suppose this panel illustrates the use of statistics well. Mr. Allegretti, you point out that insofar as the documented transportation related fatalities, that waterborne commerce accounted for less than one percent of the total number. I assume that is one percent of the total number of transportation fatalities in the country.

And yet, Mr. Turner, you point out that in the years 1981 to 1990, 2,418 bridges have been hit by commercial marine vessels; an interesting, again, use of statistics. Not a lot of fatalities, but an awful lot of accidents, and obviously the accident of September 22nd and the one in New Orleans which left a quadriplegic and death of two individuals has called our attention to the fact these accidents can leave fatalities. They can, in fact, and do translate into real fatalities, real people loss and injury.

Mr. Allegretti, you seem to have struck a chord in your testimony of cooperation in regards to the Secretary Pena's instructions to the Commandant and the National Transportation Safety Board, and with this committee in terms of working with us to see if we can't improve safety. And as I said, we will be introducing legislation to talk about plugging some of the holes.

Talk to me a little bit about what the wheelhouse looks like, what goes on, what does the operator of a tug have to rely upon today? What kind of training does he have? What kind of experience would this operator have in the river system in which he got lost?

Give us a picture, if you will, of what occurs in the wheelhouse.

Mr. ALLEGRETTI. Captain Tinkey is much better equipped to do that from the many years that he spent navigating vessels and overseeing them. Let me preface his remarks by saying that what you find today in our industry is much different than what some may think of our industry as having historically been. This is an industry with a great deal of sophistication. It is an industry that works in concert with its shippers to provide safe and reliable transportation, and that is the measure of success today.

As a consequence, what you find in the wheelhouse of a towing vessel is something that bears little resemblance to what you would think you would find if you looked only at the regulations which govern that vessel. In terms of the level of equipment, you find much more than you would ever see in the regulatory requirements. In terms of the people, you find more than is required in the Coast Guard licensing structure.

And I think that that is a point that is extremely important, and it is why we do not shrink from the kind of oversight and the kind of examination that the Secretary has directed the Coast Guard to do.

Mr. TAUZIN. Tell us what we do find. You say it is more than what the regulations require. What do the regulations require?

Mr. ALLEGRETTI. Let me speak directly to the issue of equipment, because I know that is an interest that you have with respect to the legislation. We did some work a couple of years ago, not anticipating that we would be here today, with our members, about the kind of equipment that is maintained on towing vessels; and the requirements of the regulations are simply that you have a VHF radio, a whistle, a bell, and position lights, and if you meet those requirements, you are in full compliance with the law.

Mr. ALLEGRETTI. But what you will find aboard an inland vessel that is sailing in intercity line-haul service is much more than that. You will find navigation charts. You will find navigation publications like a Light List. You will find a radar. Sometimes you will find redundant radar, searchlights, and sounders; something called a jackstaff; something called a swing meter. And you often find a backup VHF radio.

I don't want to suggest that every towing vessel in the United States maintains that array of navigation equipment. Vessels that are largely involved in localized movements will be closer to the regulatory requirements than will a vessel that is moving a large tow down the river.

Mr. TAUZIN. You are telling me that the regulatory requirements are whistles and bells? That is pretty lenient, isn't it?

Mr. ALLEGRETTI. Those are the requirements of the law, Mr. Chairman. And I might point out that those requirements are not requirements that are unique to towing vessels.

They are requirements that extend to all vessels of less than 1600 gross tons. So the gaping hole that was earlier described as applying to our industry is one that applies well beyond the confines of our industry.

Mr. TAUZIN. It may, in fact. But we are talking about this one now. We are looking at that 1600, according to Mr. Turner, accidents a year, four a day, if those statistics are accurate.

Should all we be requiring be a radio and some whistles and some bells?

Shouldn't we at least have required that, in this case, the operator have knowledge of how to operate the radar and that he have had some charts aboard that would have indicated a railroad bridge was there or that he was entering an unnavigable channel?

I mean, it seems to me that whistles and bells are just not going to do it. And, I mean, it didn't take, you know, eight months of investigatory hearings to teach me that we have a big gaping hole here and that, while most of the vessels may have these other things, that not requiring to have them on every vessel is a big mistake.

What is your reaction to that?

Mr. ALLEGRETTI. The question you posed to me is: Doesn't it make sense for this type of equipment to be carried as a matter of routine?

I can't answer that with respect to whether the American Waterways Operators will support that because it is not an issue that we have yet brought before our Board for debate, given the short time-frame of the hearing.

But I can tell you this, if the proof is in the pudding and you look at what people are carrying, they would agree with your conclusion that these kinds of navigational tools make a lot of sense because they carry them even though the government doesn't require them to.

Mr. TAUZIN. Let's talk about training. You point out in your testimony that the licensing requirements for an operator includes six months of training in the wheelhouse and three months in the particular geographic locale for which the application is made.

In the case of this accident, September 22nd, can we assume that the operator did, in fact, have six months of training in a wheelhouse and three months in the area in which Big Bayou Canot is located?

Mr. ALLEGRETTI. Yes, you can assume that, assuming that the Coast Guard's regulatory mechanism worked as it should.

But it is important to point out that in the particular geographic locale does not mean that he actually had experience on the Mobile River. It means that he had experience on the inland river system as opposed to ocean-going experience.

Mr. TAUZIN. Well, let's talk about that. Should we be more specific in terms of requiring, before licensing operators in the inland waterway system, that they are familiar with the specific river system they are going to be operating in?

We had similar discussions in the Hudson River some years ago with reference to the changing conditions of river systems and the fact that shoals come and go and that people are not intricately familiar with the specific river system they are dealing in, they can get lost and run aground and have another accident. They can be the first or the fourth one that day. It seems to me that maybe we are not specific enough in that requirement.

What are your thoughts on that?

Mr. ALLEGRETTI. I think the most important thing to say in response to that is that piloting is the essence of what a river captain does. If he isn't capable of doing that, then he doesn't have any reason to be in the wheelhouse of that vessel. And I think that is the bottom line that the companies look to in evaluating the competency and proficiency of their captains.

Captain Tinkey can elaborate on this.

Mr. TAUZIN. Maybe he can.

Captain, in the case of a barge owner or a tugboat owner who was going to employ an operator, wouldn't it make sense to hire a person who has traveled up and down that river system before?

Are Coast Guard regulations adequate enough even though you don't have to have specific knowledge of the inland river in which you will be working in?

Captain TINKEY. Certainly you make a good point. The licensing requirements have to be met. But I think companies, just from a business standpoint—and we are in a tremendous evolution in this business as we are in any business in customer service in what they expect and what they deserve, quite frankly.

Mr. TAUZIN. Yes, I think so.

Captain TINKEY. The validation of a captain or a pilot's ability is foremost in all of these companies' thoughts.

Mr. TAUZIN. Would it make sense for us to require, before licensing, that pilots of these vessels have some real time experience in the channels in which they will be navigating?

Captain TINKEY. It is my understanding that they do now, you know, with the recency of service letters that they have to have prior to that.

Mr. TAUZIN. It is something that we will want to look at. Obviously if the requirements are for whistles and bells in the wheelhouse and general knowledge of the inland waterway system, that is pretty broad; and perhaps it isn't adequate enough. We all want the same thing, people operating vessels that know where they are and know how not to hit bridges.

And if we are hitting 2,000-some-odd bridges in a 10-year period and having four accidents a day in the inland waterway system, we have some work to do here.

What I hope we don't do is do things that don't help us. That is why I want to get into the debate that you have started, Mr. Turner.

First, Mr. Allegretti, would the documentation of all the seamen aboard tugboats help in preventing accidents like the Judge Seeber Bridge accident and the accident in Big Bayou Canot?

Mr. ALLEGRETTI. We can find no evidence that it would make any contribution to safety, either with respect to these two accidents that are the subject of the hearing today or in the general type of accident which you find in our industry, which is an accident borne of human error and largely the error of the person at the sticks or at the wheel.

That is essentially the problem that we have with that legislation is that it makes no contribution to safety but it imposes requirements on us in the process.

We would be more than happy to consider changes to the system of licensure and training that do make a contribution to safety.

Mr. TAUZIN. In that regard, Mr. Turner makes a point that documenting the workers on vessels will give you a handle on the statistics, who did cause the accidents, and give you some handle on the individual. If an undocumented—currently undocumented seaman contributed to an accident, you could have that on the record and, therefore, make it more difficult for that person to be employed in that responsible position again or suspend the license or take appropriate actions that we take with licensed operators.

We have had hearings on this, Mr. Turner as you know. And we have had some concern about documenting the waitresses and the croupiers aboard gambling ships and whether that is essential.

But are there some employees aboard vessels that documentation and some training would make sense and others it would not, Mr. Allegretti?

Mr. ALLEGRETTI. Not that I can see, Mr. Chairman, beyond the people in the wheelhouse.

In order for the argument of the proponents of the legislation to have merit, you have to accept the premise that undocumented

seamen are a major reason why accidents occur on towing vessels. There is no evidence to support that allegation.

And, as a matter of fact, Mr. Turner says in his testimony that he hopes that the Coast Guard's analysis will differentiate between licensed and undocumented workers aboard vessels. We should have had that information before us before we promoted the legislation, I would think.

Mr. TAUZIN. Well let's give Mr. Turner a chance.

Give us your swing at it, Mr. Turner.

Mr. TURNER. Mr. Tauzin, first of all, your analogy in the hearing about statistics bodes well in this situation also. I agree with Mr. Allegretti in terms of what the towboat operation looks like and what it should look like with all of the updated equipment aboard these operations that are first class. That is not what we are after here, I don't think.

I think—we are not after the 90 percent that do the job as well as can be done in this industry. We applaud those moves in terms of training. We are looking for the 10 percent that are ducking under these systems.

And I think this accident, as tragic as it is, gives us an example of what could happen. You have four crew members aboard this vessel. Four. Two of them are licensed, two of them are not.

It is currently being determined who was at fault. And I am sure, given what I heard here this morning, that there is going to be a lot of attention given to the licensed personnel and what they did and did not do in that accident.

The deckhands, on the other hand, are responsible for setting out on those barges two and three hundred yards, two and three football fields, up and standing watch and determining what can be seen with the human eye and communicating that back to the pilot. That person has no responsibility under this system. If he is asleep or if he is drunk or if for whatever reason he has been involved in accidents for the last 10 years, we don't know because we can't count. The Coast Guard can't count those people because they are not under their supervision.

That is our position. We applaud the training. We would love to our—our business, frankly, is providing the best trained mariners aboard the water. But in order to do that first, you have to know who is out there.

And the documentation could do two things. Number one, it would screen those people so that we would make sure that they were not felons. We would make sure that they had no drunk and driving problems. We would make sure that they had no drug problems.

And the second thing it would do is if they had a history of being involved in accidents and being found culpable, then the Coast Guard could regulate their work experience much like the two licensed officers will likely be disciplined.

Right now, these two guys can go on down and get a job on another tow doing the same thing. And maybe they didn't do anything wrong; maybe they weren't asleep; maybe they were doing their job. But if they weren't, we can't count them. And that is why we respectfully disagree with Mr. Allegretti on this issue.

Mr. TAUZIN. Just to keep the record straight, H.R. 1915, the one you propound as a first step solution, does not, in its current form, require either training or showing any knowledge of marine operations?

Mr. TURNER. Right.

Mr. TAUZIN. And you make the point, Mr. Allegretti, that because it does not require training or knowledge of marine operations that it will not aid the safety aboard the vessel.

What about Mr. Turner's argument that some of these deckhands do serve as watch? In fact, the deckhand in the case of the incident on the 22nd, was a watch deckhand. He had been called forward because the assistant pilot feared for his safety in the fog, and he was in the mess hall at the time. But he was a deckhand on watch in ordinary circumstances.

What about the argument that maybe we need to think a little bit more about those folks?

Mr. ALLEGRETTI. That is exactly why the companies have established the level of selection that they have and why companies have voluntarily gone forward with training programs, because they want to assure that these folks who are on watch and who are making a contribution to the operation of the vessel are able to do so and that they have met certain fundamental company requirements.

I hesitate to link too closely the accident in Alabama with this legislation. But I need to respond to something that was said.

Mr. TAUZIN. Proceed.

Mr. ALLEGRETTI. I do not want the subcommittee to be under the impression that there is any linkage at all between the effect of the legislation and having avoided that accident in Saraland. In fact, two deckhands were aboard that vessel. The deckhand who was off watch had five years of experience as a deckhand, and he had successfully completed the deckhand training program offered by Warrior and Gulf. The deckhand who was on watch at the time of the accident had 12 years experience, and he similarly had graduated from the Warrior and Gulf Deckhand Training Program.

It is hard for me to fathom that if either of these individuals had received an MMD 5 years or 12 years prior to the accident, that that would have somehow prevented the accident from taking place.

Mr. TAUZIN. We are not, of course, going to settle that debate here, but I did want to give you an opportunity to have it.

I recognize the Ranking Minority Member, Mr. Coble.

Mr. COBLE. Thank you, Mr. Chairman.

Mr. Allegretti, I think you answered this, at least casually. Let me go back to it. You heard some of the proposals offered today. Would the American Waterways Operators support increasing the requirement for navigation equipment for towing vessels? That is a very general question, I will admit; and I will accept a general answer.

Mr. ALLEGRETTI. My general answer, Mr. Coble, is that our industry's practices indicate, I think quite clearly, the value that we place in navigation equipment over and above that which is already required by Coast Guard regulation.

As to whether or not the association can speak to this, that is something that first needs to be discussed with our Board of Directors.

Mr. COBLE. And, again, I am going through my exercise of applying 20-20 hindsight; but as the Chairman pointed out, had there been proper charts in the wheelhouse, there would have indicated the presence of a bridge up ahead. Had there been a compass, it would have indicated, fellows, you are off course; let's come about and correct it.

Again knowing what could have been avoided, perhaps. Mr. Turner, I put the same question to you, I suspect you all would endorse what has been proposed here in a general way, would you not?

Mr. TURNER. Yes, from what I have heard here, Mr. Coble, we certainly would. Anything that enhances training aboard these vessels, this union would wholeheartedly support.

Mr. COBLE. And regarding documentation that—the Chairman touched on this very lightly—cooks, for example, messmen, I can see—I guess depending upon the size of the vessel—if you have a vessel with a very small crew, very limited number of crew, I can see how on occasion a messman or a cook may be called from the galley to get on deck to help with deckhand duties and maybe even to assist with watchstanding duties.

Conversely, on a vessel where you, let's say, may have a particular division consisting of 15 or 20 men or crewmen, perhaps the cook would never come on board officially.

Would there be some sort of distinction, Mr. Turner, you would draw in this situation? We would like to see cooks documented because they are called upon from time to time to perform watchstanding duties or deckhand duties. However, where they are not required, they do not.

Mr. TURNER. I would agree with that, and our union would agree with that.

What we would support and do support is the same situation as you have on the deep-sea sector, which is that all licensed and unlicensed running crew must possess a document. Then the Coast Guard goes in and determines, in cruise ship situations, which personnel they would support to documentation because of their position aboard that vessel in terms of evacuation response.

That is the way it is on the deep-sea sector, and we would support anything along those lines on the inland sector. I mean, certainly a croupier, if he has no navigational responsibilities, should not have to possess a document that is intended for that purpose. The Coast Guard, we think, can go in during a situation where you have a riverboat gambling situation or a cruise ship and look at that employment and determine, well, you may have a croupier that is next to a fire exit and he may have some responsibility in terms of evacuating that boat. The Coast Guard may determine that, but that would be totally up to the Coast Guard.

Mr. COBLE. And that would be dictated by each individual situation on each individual vessel?

Mr. TURNER. Exactly. We support that 100 percent.

Mr. COBLE. Captain, did you want to add anything? I didn't mean to overlook you.

Captain TINKEY. On the issue of the charts and the compasses that you brought up and that the Chairman brought up, I think that the perception that towboats are running around out there without charts and without compasses probably is a perception that is a bit erroneous. Most towboats do carry charts.

These charts, however, on these alluvial river ways, dynamic river situations, they change frequently. So what captains and pilots—operating captains and pilots normally do is create themselves what they call a “bar book” based off of these charts. He notes changes on a day-to-day and week-to-week basis, not like a coastal chart or deep-sea chart which probably remained basically the same and designates ranges and compass courses.

This is a tool, you know, captains and pilots rely on and they keep up religiously, this kind of charting and updating.

In addition to that, the Coast Guard does broadcast navigation notices on a regular basis for changing conditions. These are also available in hard copy that can be picked up along the waterways.

But they—the operating captains and pilots, listen for these broadcasts daily for any information add-ons. I can’t speak to the coastal operations, where we are operating in the Mobile Bay area, Houston—in some of those areas, however, on—basically on the major waterways, which we deal primarily in, our radars are supplemented with what we call rate-of-turn indicators which are something like a compass, with the exception that we are really not interested in east-west direction. We are interested in what the head of the tow is doing and whether we are going to have to follow a current or a cresting current.

The rate-of-turn indicators that we use exclusively in lieu of compasses really pick up changes in headings and courses that supplement very well with radar headings and these are used exclusively and they are relied on greatly with the heavier tows.

And this is equipment that is currently in the pilot houses and widely used. Like I say, the perception as the Chairman says, the bells and whistles, we have gone way beyond that; and it is just good business to do so.

Mr. COBLE. Thank you captain. This leads me to another question, I don’t think it has been asked. It appears clear that there were no charts in the wheelhouse of this particular tug. I wonder if you all know—perhaps you don’t know—whether or not they maintained charts as a rule of thumb? Did they have charts in their possession or perhaps ashore?

Captain TINKEY. I can’t speak for that, Mr. Coble, as to what they were doing in this incident.

Mr. COBLE. Thank you, Mr. Chairman.

Mr. TAUZIN. Thank you.

The gentleman from Kentucky, Mr. Barlow.

Mr. BARLOW. Thank you, Mr. Chairman.

Mr. Allegretti—and perhaps the other gentleman can comment on this—the sequence of events here and the timeframe were very rapid. Is that a fair assertion? Just one thing happened right after another within a very short time span from the collision to the train coming along. Very little time lapsed there, is that true?

Mr. ALLEGRETTI. That is my understanding from what I have read. But I must also say that what I have read is only that which has been in the public domain.

Mr. BARLOW. Let me ask you, Mr. Allegretti and Captain Tinkey, replacement costs of these tows is considerable and it goes up all the time, like the cost of everything else.

Is that true?

Captain TINKEY. Yes, I think that that is correct, Congressman Barlow.

You know, when we send a towboat out with a crew and with a tow of our customers' cargo in barges, that is a substantial business investment. And there is very, very little motivation for us to do anything other than the best job we can of validating the competency of our people and crewing that productive unit of our business as properly as we know how.

Mr. BARLOW. What? Barge and the tows can run you up in the tens of millions of dollars; right?

Captain TINKEY. I would say that a big towboat, nine or ten thousand horsepower towboat, you are looking at a \$15-million plus investment right there.

Mr. BARLOW. So you want to be sure that you have got competent crew on there just from the standpoint of protecting the investment?

Captain TINKEY. We make every effort to assure that.

Mr. BARLOW. Your insurance fees, of course, are going up all the time, and workers' compensation is going up all the time. Is it a problem?

Captain TINKEY. Certainly is.

Mr. BARLOW. In terms of staying competitive and keeping your costs down?

Captain TINKEY. It is one of the major things that we do in effective operations, keeping our costs of damages under control and to a minimum.

Mr. BARLOW. Well, you did a remarkable job. The industry did a remarkable job in the Mississippi River over the past summer. It is just amazing. It is an untold story about how they kept the water way open and kept commerce moving there. Excellent. Excellent.

Captain TINKEY. I appreciate you making that point, Congressman. Because I think we are quite proud of our mariners, and I think the floods of 1973 and 1993, I think that you saw a group of individuals that kept commerce moving, reestablished commerce, really aided the Coast Guard and the Corps of Engineers with very, very few incidents.

In the drought of 1988 where we had absolutely no channel between Cairo and New Orleans, with the cooperative efforts of the agencies at the Corps and the Coast Guard, we were able to maintain a flow of commerce that supported this country's export programs. And we did it effectively and safely and without incident.

Mr. BARLOW. What training structure, Mr. Turner, does the union have for personnel on inland waterways?

Mr. TURNER. We have a training facility in Piney Point, Maryland, in which we train both deep sea and inland.

Specific to this situation, we have a simulator which all of our crew members go through and are trained as deckhands aboard

this simulator which simulates, of course, the currents in the marine waterways in this country.

Mr. BARLOW. No further questions.

Thank you, Mr. Chairman.

Mr. TAUZIN. Thank you Mr. Barlow.

Gentlemen, there is an old adage in the law that hard cases make bad law. And that is something that we, of course, need to be aware of as we proceed. But we have a hard case on our hands here. We really do. I mean, if the law simply required whistles and bells and a radio, this fellow appears to have had little else aboard but the whistles, the bells, and the radio. And I don't know about the whistles and bells, but there is a real question about whether or not he used his radio.

Mr. Barlow said it happened quickly, and I don't want to pre-judge it. It is not our responsibility here today. But if the accident happened at 2:45 and the train derailment occurred at 2:53, that is eight minutes to use the radio and call the Coast Guard; and I don't know that that happened. I don't know that our law requires it yet. If it doesn't, it should. Eight minutes to call is a lot of time to stop a train. And they have nothing about whistles and bells and a radar that you can't operate aboard your vessel to be lost in a fog and then proceed, as this fellow proceeded, makes a very, very hard case.

And I don't want to make any bad law out of it; but it seems to me we could make some good law if we are careful here, that working with you, as we will, we can perhaps improve on the way in which the Coast Guard licenses personnel for these vessels, maybe to make sure they can operate the radar, maybe to make sure they know how to use the radio and who to call. You call the Coast Guard, not your boss, when you have an accident like that.

And maybe we could have some new laws that require that all the better technology that you describe, Tom, in the 90 percent or better of the good operators wheelhouses be required in the other 10 percent too.

Charts, bar charts, updated, be kept by people who are accustomed to that river system and know when you make a 90 degree turn into a nonnavigable waterway. And maybe in the process of all of this, we can employ some technology that will tell an Amtrak train that something happened to your tracks other than a breakage, and maybe can alert the Coast Guard that some structure over a narrow waterway should be damaged and somebody needs to make a call.

There is a failure here of a number of systems. And it doesn't take us—and it won't take us—eight months to identify them. We are going to drop legislation in this afternoon or early tomorrow morning. We have learned a few things today that we may want to perfect in the legislation, but we will drop it in.

We are going to move to markup and have a chance to meet again to make sure that we are not making a bad law. I don't want to impose something that is not a safety improvement. And I don't want to unnecessarily require training that is not necessary. But it seems that we could make some good law here and that the Coast Guard badly needs some new instructions in this area, and that operators in general need to be as conscious, as I think the Nation is,

that when 47 people die and the systems have broken down that we need to do something about four accidents a day, 2,000 bridges struck in a 10-year period, and 1600 collisions a year. We have got some work to do. And we will be about it.

Let me thank you very much for your contributions. As I said, the arguments over documentation are going to continue as to whether that is an adequate first step. I have tried my best. I hope you got that impression, but to prejudge the specifics of these cases, I can't help but get a little emotional about the fact that this is an awfully hard case, and a lot of people died as a result. We ought never let this happen again. And we have got some work to do to make sure it doesn't.

Thank you very much.

The hearing stands adjourned.

[Whereupon, at 12:35 p.m., the Subcommittee was adjourned; and the following was submitted for the record:]

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Hearings on
Safety of the Inland Tug and Barge Industry
and Review of the Amtrak Sunset Limited Accident
at Big Bayou Canot, Alabama

Statement of
Thomas A. Allegretti
Senior Vice President - Operations
American Waterways Operators

Before the
Subcommittee on Coast Guard and Navigation
Committee on Merchant Marine and Fisheries
U. S. House of Representatives

October 12, 1993

Good morning, Chairman Tauzin and members of the Subcommittee. My name is Tom Allegretti and I am Senior Vice President - Operations for the American Waterways Operators. AWO is the national trade association representing the inland and coastal barge and towing industry, and the shipyards which build and service these vessels.

I am joined today by Captain Jerry Tinkey, Vice President of Operations for Ingram Barge Company. Captain Tinkey is with me today in an effort to be responsive to any operational questions the Subcommittee may have. His long tenure in the inland towing industry, in both executive and operational capacities, makes him well qualified to do so.

Mr. Chairman, we appreciate the opportunity to appear before the Subcommittee this morning. We applaud the speed with which you are beginning this inquiry and the equally quick action taken by the Secretary of Transportation and the Coast Guard Commandant. Our industry shares your objectives of assuring a complete examination of the circumstances of the Amtrak derailment and learning those lessons it may hold for us about the operation of vessels and trains. The most important message I can convey to the Subcommittee today is this: If the accident investigations now underway uncover system-wide inadequacies in the way our industry runs its vessels, we will be in the forefront, as a constructive partner with Congress and the Department of Transportation, of defining and implementing solutions. We must all work to assure that nothing like this ever happens again.

I must also say, Mr. Chairman, that we believe it is inappropriate to comment on or speculate about the accident itself. We are privy to no special information beyond that which has been reported in news accounts and in the statements today of the National Transportation Safety Board and the Coast Guard. Obviously, the investigations continue and we should await their results before drawing any conclusions. However, once the investigations are complete and the information is released, you can rely on AWO to work constructively with the Subcommittee to review any public safety issues which are then raised.

Mr. Chairman, the subject of today's hearing is safety in the inland towing industry. I can tell you, without fear of contradiction, and certainly with all sensitivity to the human tragedies which resulted from the accidents under review, that safety is a deep and abiding objective in this business. Our companies pursue safe operations because it is the right and moral thing to do, and because it is sound business practice. The consequences of unsafe operation -- from loss of life to enormous liabilities to government penalties to lost business opportunities -- rule it out for any company that hopes to survive, let alone prosper.

That assertion is borne out by the numerous measures which many towing companies have undertaken, at their own initiative or at the request of their customers, to enhance the safety and quality of their operations. These include increased focus on personnel training, whether through structured on-the-job programs or classroom instruction at in-house or outside facilities, and the establishment of rigorous standards for personnel selection which in many cases exceed regulatory requirements. In addition, companies in our industry have embraced the quality movement which has taken root among so many of this country's successful corporations, adopting a range of total quality management programs and entering into "quality partnerships" with the shippers they serve. Several have begun the rigorous process of achieving ISO 9000 certification.

That assertion of commitment to safety is also borne out by government statistics. Barge transportation has the lowest probability of an accident among all modes of transportation and is statistically the safest mode of transport both in absolute numbers of accidents and in lives lost. According to a 1990 report by the U.S. Department of Transportation, waterborne commerce accounted for *less than one percent* of the total number of transportation-related fatalities which occurred in 1988 in the rail, trucking, and marine modes.

Mr. Chairman, while we wish to impress upon the Subcommittee this industry's commitment to safety and our good safety record, I don't want our message to be misinterpreted. It is not that we're perfect, or that we can't do better. We can, and

we're trying. We are well aware of the fact that as long as there is even one accident, injury or casualty, we must continue to improve. We don't need to be sold on that objective.

As you know, Mr. Chairman, our industry considers personnel competence to be the linchpin in its continuing efforts to ensure that we maintain our position as the safest mode of transportation in America's transportation infrastructure. Thus, we believe the work of this Subcommittee and the specific areas of Coast Guard analysis detailed by Secretary Peña in his September 30 letter to you concerning the Amtrak accident are prudent and appropriate initiatives under the circumstances. We will do whatever we can to facilitate the Coast Guard's work in the specific areas the Secretary directed be examined -- the sufficiency and effectiveness of licensing requirements for captains and pilots on towing vessels; the accident history of wheelhouse personnel on towing vessels; and the adequacy of reporting requirements for marine casualties and hazardous conditions involving vessels and the penalties for failure to report such incidents.

The Commandant, in directing that this analysis begin, added a fourth area of inquiry, which we also stand ready to assist: The adequacy of the aids to navigation system for marking bridges and for marking the approaches to bridges over navigable waterways, and the adequacy of the navigation equipment requirements for towing vessels.

AWO believes that personnel competence and attention to training for mariners at all levels should direct the efforts of both industry and the government to ensure the highest level of safety on the waterways. The governmental side of this effort includes requirements and activities which are germane to the Subcommittee's inquiry.

- Those individuals who pilot and operate our fleets are *experienced and licensed* as required by existing statute and Coast Guard regulations. At a *minimum*, the required qualifications for an operator of a towing vessel are as follows:
 - 21 years old;
 - Three years of service, six months of which must be duty or training in the wheelhouse and three months of which must be in the particular geographic locale for which application is made;
 - Three months of required service must be performed within three years of application for license;
 - Pass Coast Guard exam;
 - Completion of an approved first aid course;
 - Completion of an approved CPR course;
 - Pass physical exam;
 - U.S. Citizenship;
 - Provide written recommendations concerning suitability for duty from recent marine employers and at least one from master of a vessel on which applicant has served;
 - Pass Coast Guard fingerprint check; and,
 - No convictions of dangerous drug offenses within three years of application (up to 10 years if facts or circumstances warrant); no history of usage of or addiction to a dangerous drug, unless applicant produces satisfactory evidence of cure.
- The Oil Pollution Act of 1990 (OPA 90) requires the Coast Guard to conduct studies evaluating crew competence questions at all levels. These studies (along with the new expedited effort detailed by Secretary Peña) should answer fundamental questions which will provide the basis for sound policy judgments about how to ensure and enhance the competence of vessel crews. The Coast Guard has indicated that it will provide these reports to Congress in 1995.
- The International Convention on Standards of Training, Certification and Watchkeeping for Seafarers (STCW) is the principal international convention which governs standards of competence for deck personnel. The International Maritime Organization is currently engaged in an expedited review process aimed at modernizing and strengthening STCW standards by mid-1995. The U.S. Coast Guard has played and will play a central role in that effort.

While these governmental requirements and activities seek to assure and promote safety, the towing industry, on its own accord and without external prompting, is moving forward with broad-based safety initiatives of its own. For example, many towing and barge companies increasingly require training for their entry-level deck personnel. Some companies have established in-house training programs which employ a mix of classroom

and on-board training; others send their new hires to outside institutions to be trained. A recent AWO survey found 17 separate deckhand training facilities now serving the needs of the barge and towing industry in the United States. Meanwhile, on-the-job training, a historical mainstay of marine industry training programs, remains widespread. Companies have taken these steps not in response to a government mandate, but in recognition of the importance of ensuring the competence of their personnel.

Additionally, the Towing Safety Advisory Committee, a congressionally-authorized advisory body to the Secretary of Transportation, is now working on an analysis of training standards for entry-level personnel for the Coast Guard. An expert group of industry, labor, government and training personnel has been comprised to work on this task. Essentially, they have been asked to evaluate whether uniform entry-level training requirements make sense from a safety perspective and whether there is an appropriate governmental role in their establishment. They are currently conducting a comprehensive assessment of this matter and will report to the Coast Guard by year end on the value of entry-level training, its proposed content, and the mechanisms available for its implementation.

We believe it is important for members of the Subcommittee to be aware that our commitment to quality personnel is not one of recent conversion. AWO has been in the forefront of calling for more rigorous requirements where we believe that government has a role in establishing such standards. For example, when the Coast Guard announced its plans in 1992 to begin a rulemaking on certification of seamen, AWO came out in favor of new physical and training standards for these mariners before any formal Coast Guard proposal was released. We did so to assure that the agency knew it could count on AWO's support for increased requirements while the proposal was still in the developmental stages.

AWO formally stated in comments submitted to the Coast Guard on May 29, 1992, our support for Coast Guard requirements which would establish both physical standards for employment on vessels and physical ability standards necessary for maintaining the safety of individuals and vessels in emergency or crisis situations. AWO also endorsed training for entry-level personnel as a valuable foundation for safe operations. AWO strongly supports the continued practice of thorough and tailored training for entry-level seamen to ensure an understanding of both vessel operations and safe work practices aboard vessels.

Finally, Mr. Chairman, I regret to raise the Merchant Mariners Document issue in the same context as issues as profound as industry safety and the fatalities which resulted from these accidents, but we are compelled to do so. AWO is very concerned by the attempt to use this tragic and unprecedented accident as a means to propel H.R. 1915 forward. We reject any reference which suggests that patterns of slovenly attention to safety and the protection of life and property exist in this industry's vessel operations. To tie passage of H.R. 1915, mandating Merchant Mariners Documents for deckhands, to improved safety on the waterways, is cynical in the extreme. We have previously detailed our objections to this bill and will only underscore here the fact that the issuance of an MMD, which requires *neither training nor showing of any knowledge of marine operations*, has no relevance to this or any other debate on safety within the industry. Indeed, we believe the foregoing treatment of safety in our industry amply demonstrates that MMDs are documents with a utility eclipsed by time and industry practice.

Mr. Chairman, thank you for the opportunity to address the Subcommittee today on a matter about which our industry cares deeply. I would be happy to answer any questions the Subcommittee may have.



National Transportation Safety Board

Washington, D.C. 20594

Testimony of
 Mr. George Reagle
 Director, Office of Surface Transportation Safety
 National Transportation Safety Board
 before the
 Subcommittee on Coast Guard and Navigation
 Committee on Merchant Marine and Fisheries
 House of Representatives
 regarding
 the Accidents that Occurred
 May 28, 1993, at New Orleans, Louisiana
 and
 September 22, 1993, near Mobile, Alabama
 October 12, 1993

Good morning Chairman Tausin and Members of the Subcommittee. I am pleased to represent the National Transportation Safety Board regarding accidents in which marine vessels strike bridges.

Before beginning, I would like to point out that approximately 24 percent of collisions involving commercial vessels in United States waters involve bridges. A recent article in World Wide Shipping compared the impact of energy of a marine vessel with 30,000 Deadweight Tons colliding with a bridge, to that of a Boeing 747 crashing into a structure at 120 knots. A dramatic comparison admittedly, but one that demonstrates the need to assure the protection of bridges over navigable waters.

As you are aware, the Safety Board is currently investigating two tragic accidents in which a bridge was struck by a marine vessel. The most recent accident occurred about 2:50 a.m. central daylight time on September 22, 1993. Eastbound Amtrak Train No. 2, the Sunset Limited with 210 passengers and crew, derailed on a CSX Transportation, Inc. (CSXT) railroad bridge over the Big Bayou Canot near Mobile, Alabama. The entire train derailed and one span and the timber trestle were destroyed.

Three locomotive units and the first four cars, including two passenger cars, left the track and were found on the east embankment and/or in the water of the bayou. A fire from the ruptured locomotive fuel tanks followed. The baggage car, an occupied crew dormitory car, and the three locomotives were destroyed by the fire. The last four cars remained upright on the bridge with one car hanging over the end of the remaining span. Forty-two passengers, two on-board service employees, and the three locomotive engineers were killed. The two on-board service employee fatalities resulted from the fire. There were 153 injuries to other passengers and crew.

Also on the morning of September 22, 1993, the towboat, MAUVILLA, operated by the Warrior and Gulf Navigation Company, was proceeding up the Mobile River from Mobile, Alabama, to Birmingham, Alabama, pushing six barges. The crew of the MAUVILLA stated that they became lost on the morning of the accident due to dense fog. Prior to the derailment, the crew thought they had run aground; however, preliminary information indicates the tow may have struck the railroad bridge.

A full team of National Transportation Safety Board (NTSB) investigators was launched to the accident scene. NTSB investigators are currently examining all aspects of the accident, including: the track; the signal system; the condition of the bridge and bridge permit and inspection records; vessel traffic in the bayou; aids to navigation; Coast Guard and company oversight of towboat operations and practices; the U.S. Army Corps of Engineers oversight of the waterway; towboat operating requirements and practices; towboat employee qualifications and training; the condition of the towboat MAUVILLA and its installed equipment; and the towboat's maintenance records.

Our investigation is in the early stages and we plan to hold a public hearing on the accident in Mobile, Alabama, before the end of the year.

A Safety Board public hearing supplements the on-scene investigation and has as its purpose the documentation of the facts, conditions, and circumstances surrounding an accident from which the probable cause may ultimately be determined, and corrective action identified to help prevent the recurrence of the accident.

During the first week of October, for instance, the Safety Board held a public hearing on another accident we currently have under investigation. That accident occurred on May 28, 1993, in New Orleans, Louisiana when the U.S. towboat CHRIS, pushing an empty hopper barge, hit the Judge Seeber Bridge (also known as the Claiborne Avenue Bridge). The impact resulted in the collapse of a bridge pier and 145 feet of the bridge's deck.

The bridge deck fell onto the barge and into the New Orleans Inner Harbor Navigational Canal. Two automobiles containing three persons, crossing the bridge at the time of the impact, also fell with the four-lane bridge deck. One of the motorists was killed and two others were critically injured.

As a result of the accident, the canal was closed to all navigation traffic for approximately 30 hours, and the bridge was closed to highway traffic for two months. The damage to the bridge was \$1.5 million and to the barge \$7,000. The towboat CHRIS was undamaged.

The Safety Board has long been concerned about bridge safety, and the Board's accident investigations have disclosed a variety of issues concerning the structural stability of bridges, the adequacy of bridge design, and the adequacy of bridge inspection programs.

For example, during the Safety Board's investigation of the 1980 ramming of the Sunshine Skyway Bridge by the Liberian Bulk Carrier SUMMIT VENTURE, in Tampa, Florida, the lack of pier protection was determined to have been a key factor in the severity of the collapse. A 1,300 foot section of the highway bridge collapsed into Tampa Bay, resulting in the deaths of 35 people whose vehicles were travelling across the bridge when the bridge collapsed.

As a result of the New Orleans tragedy, our recent hearing once again focused on the issue of pier protection in navigable waterways. Witnesses at the hearing gave extensive testimony on the State of Louisiana's bridge inspection procedures, lock operations in the New Orleans Inner Harbor Navigation Canal, and bridge maintenance and pier protection programs for highway bridges in Louisiana. A key element in the Safety Board public hearing was an extensive presentation on the American Association of State Highway and Transportation Officials (AASHTO) specifications for design provisions for highway bridges crossing navigable waterways to minimize susceptibility to damage from vessel collisions.

Federal bridge permitting procedures, including pier protection, were discussed by U.S. Coast Guard representatives, and testimony was also presented on railroad

bridge pier protection practices over navigable waterways. The valuable and pertinent information gained during our hearing adds to the facts learned during our on-scene investigation into the Judge Seeber Bridge collapse last May. The Safety Board anticipates completing the investigation of this bridge collapse in the spring of 1994.

While it is impossible to make any probable cause determinations or to discuss potential safety recommendations concerning these two tragic accidents at this time, I would like to discuss some issues the Safety Board has identified as a result of previous investigations.

The Safety Board issued its first safety recommendation regarding the collapse of a bridge struck by a vessel following an accident that occurred on November 7, 1972, in Brunswick, Georgia. Since that time, many safety recommendations have been issued to prevent collisions with bridges by marine vessels and to lessen the impact of those collisions that could not be prevented. The recommendations have been related to:

- improved bridge protection devices;
- vehicle barriers and warning devices;
- bridge marking systems;
- improving the information available to towboat operators who are required to navigate under bridges;
- requiring that towboat operators be tested on their local knowledge of waterways on which they navigate; and
- bridge vulnerability risk assessments.

The Safety Board believes that much positive work has been accomplished in these areas, but, as evidenced by the two recent tragic accidents mentioned, more is needed.

Again, the Safety Board welcomes the opportunity to appear today, and I would be pleased to answer any questions you may have.

U.S. Department
of Transportation

United States
Coast Guard



Commandant
U. S. Coast Guard

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Department of Transportation

Statement of Rear Admiral James C. Card

U.S. Coast Guard

Commander, Eighth Coast Guard District

New Orleans, LA

on the Safety of the Inland Tug and Barge Industry

Before the

Subcommittee on Coast Guard and Navigation

Committee on Merchant Marine and Fisheries

U.S. House of Representatives

Washington, D.C.

October 12, 1993

Rear Admiral James C. Card assumed command of the Eighth Coast Guard District in New Orleans, Louisiana, June 19, 1992. A native of Melrose Park, Illinois, RADM Card is a 1964 graduate of the U.S. Coast Guard Academy.

Following sea tours aboard cutters WINONA, DEXTER, and BARATARIA, he attended the Massachusetts Institute of Technology and earned two masters degrees, one in naval architecture and the other in mechanical engineering. He graduated from MIT in 1970.

From 1970 to 1985, RADM Card served as: naval architect at Coast Guard Headquarters; marine inspector at Marine Safety Office, Baltimore, Maryland; Chief of Ship Design Branch, Marine Technical and Hazardous Materials Division, Coast Guard Headquarters; and Commanding Officer of Marine Safety Office and Captain of the Port, St. Louis, Missouri.

RADM Card graduated from the Industrial College of the Armed Forces in 1986. From 1986 to 1988, RADM Card served as Chief, Merchant Vessel Inspection and Documentation Division at Coast Guard Headquarters.

RADM Card assumed command of Marine Safety Office/Group Los Angeles/Long Beach, California in June 1988. During this tour of duty, he served as federal on-scene coordinator following the "American Trader" oil spill off Huntington Beach, California.

In August 1990, RADM Card assumed the duties of Chief of Operations, Eleventh Coast Guard District. RADM Card reported to Seattle to serve as Chief of Staff, Thirteenth Coast Guard District in June 1991. In August 1991, he was selected for promotion to Rear Admiral (lower half).

His awards include the Legion of Merit, Meritorious Service Medal with three gold stars, Coast Guard Commendation Medal, Coast Guard Commandant's Letter of Commendation ribbon with one gold star, and various unit awards.

RADM Card is married to the former Jean Howell of Franklin Park, Illinois. They have two sons, Tim and Peter, and two grandchildren.

DEPARTMENT OF TRANSPORTATION
 U.S. COAST GUARD
 STATEMENT OF REAR ADMIRAL JAMES C. CARD
 ON THE SAFETY OF THE INLAND TUG AND BARGE INDUSTRY
 BEFORE THE
 SUBCOMMITTEE ON COAST GUARD AND NAVIGATION
 COMMITTEE ON MERCHANT MARINE AND FISHERIES
 HOUSE OF REPRESENTATIVES
 OCTOBER 12, 1993

Good morning Mr. Chairman and distinguished members of the Subcommittee. I am Rear Admiral James C. Card, Commander of the Eighth Coast Guard District, New Orleans, LA.

Coming before you to discuss the tragic events surrounding the Judge Seeber Bridge collision on May 28, 1993 and the AMTRAK derailment on September 22, 1993 is deeply disturbing to me. But accidents such as these demand that we review our oversight and regulatory policies concerning the nation's inland marine transportation industry.

We in the Coast Guard have a paramount interest in the safety of people who travel over as well as on the water. Even though the people who lost their lives were not passengers on vessels, their untimely deaths appear to have been the result of unfortunate accidents related to maritime commerce. All of us in the Coast

Guard work hard to minimize the number and lessen the magnitude of marine accidents through regulation and education. Yet, here I sit today to discuss the nature of, and the facts surrounding two accidents where vessels engaged in marine commerce appear to have resulted in the premature deaths of many of our fellow citizens. We in the Coast Guard are striving to do all we can to make the waterways of this nation safer. We will review our regulatory and oversight policies, and we want to work with Congress to prevent similar accidents in the future.

On September 27, 1993, as a result of the tragic derailment of the AMTRAK Sunset Limited passenger train at Big Bayou Canot, Alabama; the Commandant of the Coast Guard, as directed by the Secretary of Transportation, ordered a complete review of Coast Guard regulation and oversight of the inland marine transportation system. This review should be completed in December. The areas of review include:

- a. The adequacy and effectiveness of the requirements for licensing uninspected towing vessel operators.
- b. The history of incidents involving operators of uninspected towing vessels.
- c. The adequacy of the requirements for reporting marine casualties and hazardous conditions involving vessels and the adequacy of penalties for failure to report such accidents.

- d. The adequacy of the aids to navigation system for marking bridges and for marking the approaches to bridges over navigable waterways, and the adequacy of the navigation equipment requirements for uninspected vessels.

Although I cannot tell you what the results of this review will be, I can present to you today the details and circumstances surrounding two recent tragedies that occurred in my district and the actions we are taking.

First, allow me to begin with the Judge Seeber Bridge incident. On May 28, 1993, at approximately 2:30 PM, the towboat CHRIS, an uninspected towing vessel, was enroute from the New Orleans Inner Harbor Navigation Canal to the Mississippi River pushing one empty hopper barge, the DM3021.

During this time, the CHRIS and DM3021 were intentionally pushed up (grounded) against the southeast bank of the Inner Harbor Navigation Canal awaiting authorization to proceed through the navigational lock. In this position, the forward one-third of the empty hopper barge was pushed up against the bank, while the towboat CHRIS remained afloat in the canal. This is common practice for towboats. They ground their barges until the lock is open for their passage.

On this day, the CHRIS' crew consisted of one Coast Guard licensed operator and two undocumented deckhands.

From statements obtained from the CHRIS' crew, the CHRIS and the hopper barge were held steady on the southeast bank of the Inner Harbor Navigation Canal (by the application of one-quarter ahead speed on the port engine) while the starboard engine was in the stop or neutral position. The licensed operator and a deckhand indicated that the starboard engine had not been operating properly during the course of the day.

As a result of the starboard engine's improper performance, one of the deckhands was instructed by the operator to change the starboard engine's primary fuel filter. After the fuel filter change, the starboard engine was tested and was still found to be performing unsatisfactorily. The deckhand was then instructed by the operator to change the secondary fuel filter on the starboard engine. The second deckhand was off watch and asleep.

At approximately 2:40 PM, while the deckhand was replacing the secondary fuel filter, the operator left the pilothouse unattended to observe the fuel filter change-out in the engineroom. Both the operator and the deck hand stated that they were in the engineroom for approximately five minutes. During this time the port engine was operating and clutched in the forward position with the starboard engine stopped. After completion of the filter change, they restarted the starboard engine.

At this time both men proceeded to the galley on the main deck to clean their hands. At approximately 2:45 PM, the operator noticed that the CHRIS and the hopper barge were underway and proceeding south on the Inner Harbor Navigation Canal at a slow speed toward the Judge Seeber Bridge. The operator ran from the galley to the pilothouse located on the third deck. Upon reaching the pilothouse, the operator reversed both main engines. Unfortunately this action did not prevent the hopper barge from making contact with one of the support columns on the southeast section of the bridge. The southeast section of the bridge collapsed, causing two injuries and one death, involving motorists who were crossing the bridge at the time of the incident. One person remains hospitalized. The bridge was in compliance with its permit at the time of the accident.

The Coast Guard response to this casualty was immediate and effective. Coast Guard personnel on the Coast Guard Cutters PAMLICO, WEDGE and WHITE HOLLY witnessed the collision and bridge failure. Our personnel immediately contacted the Operations Center at Group New Orleans and called 911 to report the accident. Each of these vessels launched a small boat within five minutes to begin rescue operations. I am proud to say they were the first on scene. Coast Guard helicopters from Air Station New Orleans, personnel from Marine Safety Office New Orleans, and medical personnel from Support Center New Orleans arrived on scene within thirty minutes of the accident to provide

additional assistance. Also immediately on scene were various city law enforcement and emergency medical personnel.

The operator of the towboat CHRIS was charged with negligence by Coast Guard investigating officers. At the administrative hearing held on September 3, 1993, the vessel operator pleaded "No Contest." The Administrative Law Judge found the charges proved, issued his decision and order whereby the operator's license was suspended for four months with an additional six month suspension on twelve months probation. The vessel operator had been operating towing vessels for more than 16 years and had no previous Coast Guard action against his license.

The second tragedy involved the September 22, 1993 derailment of an AMTRAK passenger train in Big Bayou Canot near Mobile, Alabama.

At 3:05 AM, September 22, 1993, Marine Safety Office Mobile received a report via telephone from the CSX (Railroad Company) bridge tender at the Chickasaw Bridge that a passenger train derailment occurred at Bayou Sarah and the train was in the water. At approximately the same time, the towboat MAUVILLA radioed "Mayday" to Group Mobile. The MAUVILLA informed them that its barges had broken free. At 3:08 AM, the MAUVILLA called Group Mobile and stated that there was a train derailment with fire and people in the water.

The bridge tender's report was based on a radio transmission from the conductor of the derailed train to the Chickasaw Bridge tender who had a railroad radio. The original reported position (around Twelve Mile Island and the Cut) was approximately one mile from the actual accident which occurred at the Big Bayou Canot crossing. The initial report from the MAUVILLA indicated he was also confused as to his location.

The Marine Safety Office immediately called Coast Guard Group Mobile. The Group is the primary point of contact for search and rescue for this area. After notifying the Group, the Marine Safety Office received a call from CSX at 3:09 AM, confirming the report and that the crash involved an AMTRAK passenger train. The Captain of the Port for Mobile closed the Mobile River to marine traffic to facilitate rescue operations.

Before I summarize our activities, I would like to mention to you that a number of commercial vessels, and state and local agencies responded immediately upon hearing of the accident. We were a part of that team responding to people in need.

The first Coast Guard asset on scene was a utility boat from Station Mobile. The utility boat was on scene at 4:25 AM. The first helicopter was on scene at 5:25 AM. By 9:00 AM there were seven Coast Guard aircraft on scene or in the vicinity: four helicopters from Air Station New Orleans, and two helicopters and a Falcon jet from Aviation Training Center overhead. Also by

9:00 AM a total of nine Coast Guard vessels were on scene. These included not only the utility boat mentioned above, but also a 55 foot aids to navigation boat, a 27 foot ports and waterways safety boat, and several rigid hull inflatables from Station Mobile. Coast Guard aircraft were involved in transporting accident victims from the scene to either Aviation Training Center Mobile for triage and further transport to local hospitals, or directly to the hospital if their condition warranted. Coast Guard helicopters searched the area around the accident the first day until sunset and resumed searching at first light the next morning.

The Coast Guard small boats and Coast Guard Auxiliary vessels enforced a safety zone established around the accident site due to a number of unauthorized spectator boats in the area. In addition, the small boats provided logistics support, security for the suspect barges, and transportation for other agencies' personnel. The safety zone was cancelled September 27, 1993. Besides the surface safety zone, the Falcon jet enforced a five mile flight restriction zone around the site.

A Coast Guard representative was dispatched to the site of the Mobile Fire Department emergency command post at the Cochrane Bridge over Three Mile Creek. Marine Safety Office Mobile requested that CSX keep the Chickasaw Creek railroad bridge open for emergency marine traffic. At approximately 8:30 AM, the command post was reestablished within the Port of Chickasaw.

Daily operations at the command post included; logistical support for federal, state and local agencies, media coordination with fire/police public information officers and coordination of transportation of the press to and from the scene. Command post watches were concluded on September 25, 1993.

Marine Safety Office Mobile provided a representative throughout the salvage of the rail cars and bridge. He coordinated salvage planning and recommendations with the FBI, NTSB, CSX, salvage contractors and AMTRAK. Salvage operations of the rail cars and bridge sections concluded on September 27, 1993.

The Marine Safety Office's Senior Investigating Officer initiated the Coast Guard casualty investigation. During his initial interview, the MAUVILLA's crew denied any involvement with the incident. The investigator returned to the scene to investigate any damage to the barges. After the discovery of the barges with damage and concrete embedded in the bow (possibly from the bridge), FBI agents on scene assisted by Coast Guardsmen then gathered and secured the evidence. FBI agents were on scene to investigate whether Federal criminal law may have been violated.

Early that day it was determined that the National Transportation Safety Board (NTSB) would conduct the accident investigation. We assigned an investigator as a member of the NTSB Marine Group. The Federal Railroad Administration assigned inspectors to each of the Rail Groups.

In addition to the accident investigation, the local agency (Mobile County) criminal task force is investigating all aspects of the casualty for possible criminal involvement. Members of the task force include the Alabama Marine Police, FBI, Mobile District Attorney, Mobile Police and Mobile County Sheriff's Department. The Coast Guard's role is to provide maritime expertise to the investigation, assist with interviews of vessel personnel, and to provide knowledge of standard procedures of the towing industry. The task force investigation is ongoing.

The Coast Guard is waiting for the results of the NTSB and criminal investigations before determining what, if any, administrative or civil penalty actions will be initiated against any of the involved parties.

In addition to the review being conducted by the Commandant, the Eighth District has looked at several aspects of the case to improve our operation. First, we developed and published a bridge notification protocol which provides guidance for all units on reporting a vessel collision with a bridge. This guidance is intended to immediately provide bridge owners information that a vessel has collided with their bridge. We will do this for all reported collisions so that rapid notification can be made to the bridge owners.

The guidance additionally requires the local Coast Guard units to establish liaison with all bridge owners in their area of responsibility. Each unit and bridge owner will test their communications through 24-hour emergency contact persons.

Second, we are reviewing our aids to navigation in the Mobile River. The Coast Guard Waterways Analysis and Management System (WAMS) is a framework for individually examining our navigable waterways. The goal of the program ensures the waterways are marked by an efficient aids to navigation system that promotes safe navigation and the efficient flow of commerce. WAMS encompasses all aspects of our marine thoroughfares including the physical dimensions of a channel, bridges, marine facilities, obstructions, traffic density and patterns, vessel size, and vessel traffic services.

We are currently reviewing a Waterways Analysis and Management System report of the Black Warrior - Tombigbee Waterway, which includes the Mobile River. This analysis was completed in October 1992 and at that time determined that the aids to navigation were adequate.

Third, we have investigated the bridge lighting on Big Bayou Canot Bridge. Our initial investigation showed that the bridge was built in 1909 under the bridge statutes' advance approval provisions. Title 33 of the Code of Federal Regulations, Section 115.70 states, "The Commandant has given advance approval to the

location and plans of bridges to be constructed across reaches of waterways navigable in law, but not actually navigated other than by logs, log rafts, rowboats, canoes and small motorboats." Since Big Bayou Canot is not used for commercial navigation nor transited during night time hours, the bridge was not required to be lit. If the bridge were built today, it would not require a permit, lighting, nor fendering under our current statutes. The bridge is fixed and its height prevents commercial traffic from using the bayou for commerce, and is so noted on navigation charts of the Mobile River.

I realize that no amount of investigation and analysis can restore the lives lost in these tragedies. The Coast Guard is proceeding on many fronts to improve waterway safety. In addition to the actions listed above, we in the Eighth District have initiated a complete review of all towing industry marine casualties including bridge collisions within our district's waters. Each of our seven Marine Safety Offices will be holding meetings with the towing companies within their area of responsibility to focus on local problems and communicate our concern for safety. In addition, I will be holding a summit meeting later this month with the leaders of the towing industry and their industry association, the American Waterway Operators. These actions are aimed at identifying local problems and solutions that are in the purview of the district, as well as heightening the safety consciousness of the towing industry. Our local actions, plus the more global work being done by the Commandant should improve the safety of our inland waterways.

Thank you for the opportunity to testify. I am available for your questions.



U.S. Department
of Transportation
**Federal Railroad
Administration**

400 Seventh St. S.W.
Washington, D.C. 20590

OCT 25 1993

The Honorable Billy Tauzin
Chairman, Subcommittee on Coast Guard
and Navigation
U.S. House of Representatives
Washington, D.C. 20515-6230

Dear Mr. Chairman:

During the hearing of the House Subcommittee on Coast Guard and Navigation on October 12 concerning the safety of the inland tug and barge industry, a question arose regarding a railroad drawbridge accident that occurred in the vicinity of Mobile, Alabama, in 1931. It was thought to have occurred at the same bridge over Bayou Canot that was the scene of the Amtrak accident of September 22.

The accident in question occurred on February 25, 1931. The accident location was Louisville and Nashville Railroad (L&N, now CSX) Bridge 193 over the Mobile River. That bridge, known commonly to river pilots as "Fourteen Mile Bridge," is 4 miles north of CSX Bridge 196 at Bayou Canot.

At 12:55 a.m. on that date northbound L&N train number 98, the Pan American, failed to stop at a stop signal while Bridge 193 was open for river traffic. The locomotive, tender and baggage car ran off the bridge and into the water, causing the death of the engineer, fireman, baggageman and a Pullman porter.

The bridge had been opened for a barge tow headed downstream in the Mobile River. That tow was approaching the open bridge when the train accident occurred, after which the tow turned toward the north to avoid the railroad equipment in the water. In turning, a barge of the tow struck the north or long pier of the draw span, causing minor damage to the fender system at that pier.

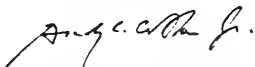
Bridge 193 over the Mobile River is incidentally the same bridge that was damaged by marine traffic on October 11, when a vessel struck and damaged the locking wedge mechanism.

As further information, Bridge 196 at Bayou Canot was never a moveable bridge, despite media reports to the contrary. The bridge was designed structurally in 1909 as a swing bridge, but

the operating machinery was never installed. Bridge 196 remained fixed in position from 1909 until September 22.

I hope this information is useful to you and the members of the Subcommittee.

Sincerely,

A handwritten signature in dark ink, appearing to read "Grady C. Cothen, Jr.", with a stylized flourish at the end.

Grady C. Cothen, Jr.
Associate Administrator
for Safety

SIU



AFFILIATED WITH THE SEAFARERS INTERNATIONAL UNION OF NORTH AMERICA • AFL-CIO

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TESTIMONY
OF THE
SEAFARERS INTERNATIONAL UNION
OF NORTH AMERICA, AFL-CIO
BEFORE THE
SUBCOMMITTEE ON COAST GUARD
AND NAVIGATION
COMMITTEE ON MERCHANT MARINE AND FISHERIES
U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, D.C.
OCTOBER 12, 1993

FAX (301) 899-7355

A-100-11

Mr. Chairman and Members of the Subcommittee:

I am Terry Turner, Director of Government Relations for the Seafarers International Union of North America, AFL-CIO, representing thousands of seamen and boatmen employed on U.S.-flag vessels engaged in the international and domestic trades. I appreciate the opportunity to appear before you today to address two recent tragic accidents which have led to an untimely and disastrous loss of life and to determine what can be done to prevent such tragedies from recurring.

In the last two weeks, we have unfortunately witnessed the tragic and senseless deaths and injuries which resulted from the derailing of the Amtrak Sunset Limited into the Bayou Canot, outside of Mobile, Alabama. As you know, investigators believe that a wayward barge struck and weakened a railroad trestle shortly before the disaster which took the lives of 47 people. The accident is still under investigation as many significant questions and crucial conflicts in evidence and witness accounts remain unanswered.

The four crewmembers of the tugboat *MV Mauvilla*, which pushed six barges laden with steel, coal and woodchips into the unnavigable Bayou Canot, have been interviewed by the National Transportation Safety Board in the presence of their attorneys. According to the interviews, the pilot (assistant operator) and one deckhand were on watch while the captain and second deckhand were asleep. The deckhand who had the same watch as the pilot was sitting in the messroom when he "felt a thud about 2:45 a.m." Although all four crewmembers are charged with navigating responsibilities and must work together as a team, the captain and pilot are the only members of the

crew that are required to hold Coast Guard licenses. Neither deckhand was documented, nor are they required to be. As a result, their work habits and personal history are not subject to the same scrutiny by the Coast Guard as those mariners who are required to hold documents or licenses as a basis for employment.

The second accident occurred at the end of May when a barge, DM 30-21, struck the four-lane Claiborne Avenue bridge in New Orleans, sending two cars and a 200-foot chunk of the structure into a shipping canal 45 feet below. One pregnant woman was killed and two men injured; the accident left one of the men, who is still hospitalized, a quadriplegic. The accident remains under investigation; no one knows what caused the barge to crash into the bridge. Media reports quote crewmen as saying that the empty barge drifted free from the bank where the tug had stopped for engine work. The National Transportation Safety Board held a two-day hearing on this accident in New Orleans only last week.

Although most tug/barge accidents are not highly profiled or garner much media attention as in the accident involving Amtrak's Sunset Limited, they do point to the hazards of shipping on the nation's inland waterways. As reported in the Mobile Register, more than four times a day -- 1,600 times a year -- barges are involved in an accident. There were 11,586 accidents involving tank and freight barges between 1983 and 1989. Statistics also show that 2,418 bridges were struck by commercial marine vessels between 1981 and 1990. From these figures, it appears that the degree of safety

in tug and barge commerce needs to be addressed before we are again faced by another disastrous incident.

For the last two years, the SIU has insisted that a potential for catastrophe exists on the nation's inland waterways. No longer is this prophetic; the Sunset Limited has made it all too real. At the same time, the SIU has forcefully asserted that operational crews on inland waterway vessels have an intense responsibility for the safety of these vessels, their crews, the environment, and the public-at-large that share these waterways. Yet, something went very wrong. As has been alleged, a barge pushed by the tug *MV Mauvilla* struck the bridge and may have possibly caused or contributed to this tragic incident.

As a result of this tragedy, many tenable questions have surfaced concerning the activity of the crew aboard the vessel prior to the accident. Hopefully, these questions will be answered and culpability determined when the National Transportation Safety Board and other investigatory bodies complete their probe and publish their report. However, as we are all well aware, an inquiry of this magnitude and complexity will take time. Meanwhile, tugs and barges and their crews will continue business as usual.

Even though no finding of probable cause will be made until the investigation is completed, the Secretary of Transportation has directed the Coast Guard and the Federal Railroad Administration "to examine existing and proposed safety programs to

ensure that we are prepared to take any necessary actions to prevent, insofar as possible, a recurrence of this type of accident." As we understand, the Coast Guard will review the adequacy and effectiveness of the licensing requirements for operators of uninspected towing vessels; the history of incidents involving operators of uninspected towing vessels; and, the adequacy of the requirements for reporting of marine casualties and hazardous conditions involving vessels and the adequacy of the penalties for failure to report such incidents.

Although we certainly welcome such a review, the SIU believes that the history of incidents on the inland waterways should also include a differentiation between those caused by documented versus undocumented crewmembers. The SIU further advances that one of the first steps to begin to improve safety on vessels plying the nation's inland waterways is for the Congress to require and the Coast Guard to issue merchant mariner documents to individuals who desire to obtain employment on vessels in the inland waterborne trades.

Furthermore, we must reemphasize that the Coast Guard has absolutely no authority or oversight over undocumented seamen. Unlike seamen in the deepsea sector, crews employed on tugs, tows, barges, and offshore supply vessels on the inland waterways are not required to hold mariner documents as a basis for employment. If these individuals were indeed required by statute to obtain these documents, the Coast Guard would have the authority to revoke or suspend the documents for cause, thereby

precluding unfit mariners from employment in this or any other commercial maritime sector. Without some form of fundamental entry-level document, there is no way the Coast Guard can prevent the reemployment of undocumented workers who cause accidents. It is that simple.

The first step to alter this situation lies in the hands of this Subcommittee. As you know, legislation requiring the documentation of merchant mariners employed on the inland waterways was the subject of consideration during hearings held last month by this Subcommittee. A similar bill passed the House last session; unfortunately, the Senate failed to take action on the bill prior to the adjournment of the 102nd Congress.

Current inaction on H.R. 1915 brings to mind the 12 to 15 years of deliberation by the Congress of oil pollution legislation. The Oil Pollution Act of 1990 was overwhelmingly passed but only after the disaster of the *Exxon Valdez* oil spill and the emotions that took control of the debate. Congress quickly responded to the blackened beaches, sick otters, and birds soaked by the oil stream. As a result, the Oil Pollution Act of 1990 is much more punitive in nature than earlier versions considered during that twelve to fifteen year period. In fact, the final product differed substantially from the legislation that was developed by the Merchant Marine and Fisheries Committee itself and enveloped vessel operators and vessel crewmembers with an array of stringent requirements.

In comparison, we have debated the merits of merchant mariner documentation legislation for the last several years. Once again, a serious accident has brought to the forefront the need to upgrade the safety requirements of tugs and barges and their crews on the inland waterways. H.R. 1915 can be the first step to reach this worthy objective. It is simple and uncomplicated legislation and certainly not punitive with respect to vessel crews. Still, it will add an appreciable measure of safety to this segment of the maritime industry. We cannot and should not relegate this legislation to oblivion only to be revived with the occurrence of still another serious accident which may command more costs in lives and damage to the environment.

Thank you.

PART 118—BRIDGE LIGHTING AND OTHER SIGNALS

Sec.

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- 118.15 Penalty for interference or obstruction.
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- 118.95 Lights on structures not part of a bridge or approach structure.
- 118.100 Retroreflective panels on bridge piers.
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AUTHORITY: 33 U.S.C. 494; 14 U.S.C. 85, 633; 49 CFR 1.46 (b) and (c).

SOURCE: 40 FR 24898, June 11, 1975, unless otherwise noted.

§ 118.1 General requirements.

All persons owning or operating bridges over the navigable waters of the United States or any international bridge constructed after March 23, 1906, shall maintain at their own expense the lights and other signals required by this part.

[CGD 84-022, 51 FR 16312, May 2, 1986]

§ 118.3 Incorporation by reference.

(a) In this part, portions or the entire text of certain standards and specifications are incorporated by reference as the governing requirements for materials, equipment, tests, or procedures to be followed. These standards and specification requirements

specifically referred to in this part are the governing requirements for the subject matters covered, unless specifically limited, modified, or replaced by the regulations.

(b) These materials are incorporated by reference into this part under 5 U.S.C. 552(a) with the approval of the Director of the Federal Register. The Office of the Federal Register publishes a table, "Material Approved for Incorporation by Reference" which appears in the Finding Aids section of this volume. In that table are found citations to the particular sections of this part where the materials are incorporated. To enforce any edition other than the one listed in paragraph (c) of this section, notice of the change must be published in the *FEDERAL REGISTER* and the material made available. All approved material is on file at the Office of the Federal Register, Washington, DC 20408 and at U.S. Coast Guard, Room 1410, 2100 Second Street, SW., Washington, DC 20593. Copies may be obtained from the sources indicated in paragraph (c) of this section.

(c) The materials approved for incorporation by reference in this part are: Federal Highway Administration (FHWA), 400 Seventh Street, SW., Washington, DC 20590

Standard Alphabets for Highways Signs, 1966. (Reprinted April 1984).

[CGD 84-022, 51 FR 16313, May 2, 1986]

§ 118.5 Penalty for failure to maintain.

Any person required to maintain lights and other signals upon any bridge or abutment over or in the navigable waters of the United States who fails or refuses to maintain such lights and other signals, or to obey any of the lawful rules and regulations relating to the same is subject to a penalty as provided in 14 U.S.C. 85.

§ 118.10 Interference or obstruction prohibited.

No person shall obstruct or interfere with any lights or signals maintained in accordance with the regulations prescribed in this part.

TESTIMONY

OF

DENNIS F. SULLIVAN

EXECUTIVE VICE PRESIDENT AND

CHIEF OPERATING OFFICER

NATIONAL RAILROAD PASSENGER CORPORATION

BEFORE THE

SUBCOMMITTEE ON COAST GUARD AND NAVIGATION

TUESDAY, OCTOBER 12, 1993

Good morning. My name is Dennis F. Sullivan, and I am Amtrak's Chief Operating Officer. Before I start, I would just like to take a moment to say how deeply saddened I -- and all of us at Amtrak -- feel about the tragedy that happened on September 22 on Amtrak's Sunset Limited. I want to extend our heartfelt condolences to the families of all of those who did not survive this accident: the 42 passengers, as well as Amtrak crew members Ronald Quaintance, John Wilson, Ernest Russ, Billy Ray Hall, and Michael Vinet. They will be missed.

I am here today to briefly state the facts related to Amtrak's operation and answer any questions that I can for the Committee. I want to emphasize that my testimony will be limited to what we know about Amtrak's operation.

At the time of the accident, the Sunset Limited, which was traveling from Los Angeles to Miami, had three locomotive units and eight cars and was carrying 192 passengers and 18 employees. The accident occurred while crossing the Big Bayou Canot Bridge approximately 10 miles north of Mobile, Alabama. This section of railroad is level and tangent with continuously welded rail.

The train derailed because a section of the bridge had been struck by a tug and its barges and had been knocked out of line about three and one half feet. This shift left a bridge girder fouling the track for our oncoming train. When Amtrak's locomotive struck this girder, the bridge collapsed, and the Amtrak trains derailed and plunged into the water. All three locomotive units and four rail cars went off of the bridge. The lead locomotive was embedded in the mud of the east bank of the Bayou and tragically, one rail car (a coach) was entirely submerged in 25 feet of water.

There is no evidence indicating any failure on the part of the Amtrak train crew or equipment or on the part of CSX's track, signal system or bridge. In fact, if anything, our Superliner cars demonstrated some of the benefits of recent safety design improvements, particularly the superior braking that prevented four cars from tumbling into the water. Toxicological tests conducted by the National Transportation Safety Board on the crew members who operated the train have found no evidence of drug or alcohol use.

Even though the bridge shifted three and a half feet, the signal system remained fully operational. Since the track had not been broken, the circuit remained intact.

While we are not prepared to discuss the details of the investigation, Amtrak is convinced that the bridge shifted because it was struck by a commercial tug pushing six barges. The bridge is low, only 7 feet above the water, and is over a body of water which is not used for commercial river transportation or by vessels at nighttime and is not a navigation channel. The railway bridge was designed to be a "swing bridge;" however, to the best of our knowledge it has never been used as a "swing bridge" to allow water traffic to pass. This railroad bridge has been at this location and in its same general configuration for over a century -- it was bolted shut to fix it in place fifty years ago. This bridge is inspected annually and was last inspected by CSX Transportation on February 10 of this year. The track itself is inspected twice weekly and was inspected on Sept. 19, 1993. No problems were reported. At about 2:01 a.m., about an hour before the Amtrak accident, a CSX freight train crossed the bridge traveling in the same direction. It crossed without incident. The CSX train had 74 cars and was approximately five times as long and weighed about eight times more than Amtrak's Sunset Limited.

CSX Transportation has estimated the time of derailment to have been 2:53 a.m. The Sunset Limited passed the last controlled signal at 2:48:48 a.m. We understand that the train speed tapes are still undergoing calibration by the National Transportation Safety Board, but we believe that, once all the



evidence is available, it will be determined that the bridge was struck and its girder span shifted between 2 and 3 a.m. -- the time between when the CSX train crossed safely and the Amtrak train derailed.

There appears to be little question that this accident was caused because a vessel or vessels struck the railway bridge with sufficient force to knock its girder span approximately three and a half feet off center and that it happened after 2:01 a.m., when CSX calculates that its freight train crossed this same bridge safely. Unfortunately, no report was made to authorities within sufficient time to allow the authorities to notify the railroad nor was any report made to the railroad. Had either such reports been made, CSX could have imposed a stop signal or sent a radio warning to the crew on the Sunset Limited, stopping the train before it reached Big Bayou Canot Bridge.

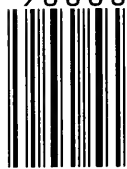
Mr. Chairman, this was a tragic accident; the worst accident in the history of Amtrak. We are all profoundly shaken. At Amtrak we grieve over the loss of five fine crew members, and we share the grief of the families of the passengers who did not survive. We are working closely and cooperating fully with investigators to determine the cause of this accident, and to ensure that whatever precipitated this tragedy does not happen again. Thank you.



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